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Waivers and Exemptions for Health Services in Developing Countries

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Ursula Giedion

March 2003

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Social Safety Net Primer Series

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Abstract

In response to shortages in public budgets for government health services, many developing countries around the world have adopted formal or informal systems of user fees for health care. In most countries user fee proceeds seldom represent more than 15 percent of total costs in hospitals and health centers, but they tend to account for a significant share of the resources required to pay for non-personnel costs. The problem with user fees is that the lack of provisions to confer partial or full waivers to the poor often results in inequity in access to medical care. The dilemma, then, is how to make a much needed system of user fees compatible with the goal of preserving equitable access to services. Different countries have tried different approaches. Those which have carefully designed and implemented waiver systems (e.g., Thailand and Indonesia) have had much greater success in terms of benefits incidence than countries that have improvised such systems (Ghana, Kenya, Zimbabwe). Key to the success of a waiver system is its financing. Systems that compensate providers for the revenue forgone from granting exemptions (Thailand, Indonesia, and Cambodia) have been more successful than those who expect the provider to absorb the cost of exemptions (Kenya). Where waiver systems exist, performance will improve with the timeliness of the reimbursement. Other success factors include the widespread dissemination of information among potential beneficiaries about waiver availability and procedures; the awarding of financial support to poor patients for non-fee costs of care, such as food and transportation (as in Cambodia); and the existence of clear criteria for the granting of waivers, thereby reducing confusion and ambiguity among those responsible for managing the system and among potential recipients. Those facing the task of adopting a system of waivers face multiple design options. These include the following, among others: should exemptions be granted to whole groups or on the basis of individual targeting (the review finds that most systems are based on the latter)? Should waivers or exemptions be permanent or temporary? How frequently should eligibility be reassessed? Should waiver eligibility be determined ex-ante, in the household, or when individuals seek care in the facility? The review examines various approaches taken by countries, but assessing their relative practical merits is difficult, as the evidence is scattered and mixed.

Acknowledgements

This paper was made possible thanks to the contributions and support of many individuals. Margaret Grosh commissioned the work, made insightful remarks on an earlier draft, and provided needed links with country experts. Marty Makinen, John Blomquist, and David Gwatkin also offered critical input on an earlier version. William Newbrander, David Collins and Lucy Gilson kindly made their work on this subject available, *Ensuring Equal Access to Health Services* (Newbrander *et al.*, 2000), a must-read for those interested in the issue of poor protection mechanisms under cost recovery in health. The authors are grateful to all those who provided first hand country information and who facilitated documents on user fees and poor protection mechanisms: Helen Dzikunu, Randy Ellis, Liliana Escobar, Wim Hardeman, James Knowles, Keese Kosterman, Tom McGuire, Wasunna Owino, Menno Pradhan, Gonzalo Sanhueza, and Robert Sparrow. Finally, they thank Alex Preker, Maria Luisa Escobar, Paul Shaw, Tim Johnston, Jerry La Forgia and all the other participants in the World Bank Seminar on this subject in June 2002.

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Acronyms

Acronym	Country	Meaning
Ausaid		Australia's Agency for International Development
CASEN	Chile	Socioeconomic Characterization Survey
CIMU	Indonesia	Central Independent Monitoring Unit
CSMBS	Thailand	Civil Servants Medical Benefits Scheme
DIY	Indonesia	Province of Daerah Itimewah Yogyakarta
EF	Cambodia	Equity fund
FONASA	Chile	National Health Fund
GTZ		Deutsche Gesellschaft für Technische Tusammenarbeit
GOT		Government of Thailand
IADB		Inter-American Development Bank
IDT	Indonesia	"Left behind" villages (poorest villages)
ISAPRE	Chile	Private Health Insurance Firm
LEB		Life expectancy at birth
LIC	Thailand	Low Income Card
MOF	Thailand	Ministry of Finance
MOH		Ministry of Health
MOPH	Thailand	Ministry of Public Health
MSA	Suriname	Ministry of Social Affairs
MSH		Management Sciences for Health
NESDB	Thailand	National Economic Social Development Board
NIDA	Thailand	National Institute of Development
NTB	Indonesia	The province of Nusa Tenggara Barat
OD	Cambodia	Operational District
ODA		Official donor assistance
PAF	China	Poverty Alleviation Fund
(PPHUP)	Cambodia	Phnom Penh Urban Health Project
SDF	Zimbabwe	Social Development Fund
SISBEN	Colombia	Beneficiary Identification System
SSS	Thailand	Social Security Scheme
USAID		United States Agency for International Development
VHCS	Thailand	Voluntary Health Card Scheme
WHO		World Health Organization

1 User fees for health services: concepts

1.1 Introduction

Following a dramatic rise in living standards over the last decades, extreme poverty –defined as living on less than $1 per day– declined only slowly in developing countries during the 1990s, and the number of poor people remained roughly constant as the population increased. Poverty has been rapidly rising in Europe and Central Asia, and remains on the increase in Sub-Saharan Africa. In Asia, where most of the world's poor live, the proportion of people living in poverty had shown sharp declines over the past two decades, but the recent crisis has slowed progress (World Bank, 2001a). International agencies are putting poverty on the forefront of their agendas. At the United Nations' International Millennium Summit a declaration was issued containing main development goals and targets. Foremost is the Summit's commitment to reduce to half the proportion of people whose income is less than $1 a day.

The world community is increasingly concerned about ways to combat poverty and to construct social safety nets that help the poor to get out of poverty while preventing the near poor from falling into it. Ill health is related to poverty and it is no coincidence that 4 out of the 18 development targets in the Millennium declaration are directly related to health. In its poverty reduction strategy sourcebook, the World Bank states: "poverty is both a consequence and a cause of ill health".[1] Poor people often lack the financial resources to pay for some health services and ill health can undermine a household's ability to cope financially. In many developing countries formal or informal user fees for health services are widespread and tend to account for a significant share of the financing for non-personnel costs. Thus, health systems in developing countries have come to rely on user fees. Yet where there is a lack of provisions to confer partial or full waivers to the poor user fees may lead to inequity in access to medical care. The dilemma, then, is how to make a much needed system of user fees compatible with the goal of preserving equitable access to services. Hence the interest in analyzing different mechanisms to mitigate the impact of user fees on access to health services by the poor.

This paper is devoted to an analysis of this issue. Chapter 1 examines the consequences of user fees on the poor. Chapter 2 discusses at the conceptual level ways of protecting the poor when user fees are in place. Chapter 3 presents detailed case studies from seven developing countries with poor protection mechanisms in health. To conclude, Chapter 4 offers lessons learned and best practices.

The remainder of this chapter is organized as follows. Section 1.2 briefly provides a historical perspective on the emergence of user fees for health care in developing countries. Section 1.3 reviews the arguments found in the theoretical and empirical literature in favor and against user fees in health care. These two sections introduce the role of waivers and exemptions in the context of health financing. Section 1.3 defines equity in health. Section discusses the economic rationale for the commonly used protection mechanisms of waivers and exemptions.

1.2 The emergence of user fees

Although there is widespread recognition of the role that good health plays in human development, not all governments have had the ability or willingness to increase spending in the health sector, or to improve spending efficiency. Over the past two decades, as government budgets for the social sectors have failed

[1]. See World Bank 2001 Poverty Reduction and the Health Sector, The Nutrition and Population Network's Chapter in the World Bank's Poverty Reduction Strategy Sourcebook

to keep up with population growth and demand, many poor countries have resorted to the widespread implementation of formal or informal user fees for health care in government health systems.[2]

Today user fees constitute an important source of financing for health care in most regions of the developing world. In some countries, such as India, Nigeria, Pakistan, Cambodia, and Vietnam, out-of-pocket spending accounts for more than half of total (public and private) health expenditure. User fees play a predominant role in the financing of HIV/AIDS health services as well. The AIDS epidemic has had profound implications for health systems around the world, including their financing and user fees have also emerged as a main source of funds for HIV/AIDS care. In Rwanda, they represent over 90 percent of all resources devoted to the treatment of HIV/AIDS (Schneider 2001).

In the mid 1980s, the World Bank, along with USAID and UNICEF, was a leading international development agency promoting the adoption of user fees for health care in the public health sector of developing countries (World Bank 1987). Whereas many nations, such as Cambodia, had had user fees for government health services well before the 1980s, the influence of these development agencies was partly responsible for the proliferation of user fees. The World Bank recognized that fees could limit access to health services by the poor, and therefore most of its policy papers prescribed that fees should be accompanied by appropriate systems of waivers (De Ferranti 1985; Griffin 1992). But despite their theoretical appeal, the viability of waivers and exemptions is an empirical question. Some authors were skeptical throughout that such mechanisms could be adopted, and criticized the World Bank for overlooking the practical difficulties of implementation (Gilson 1988). Since the early 1990s the World Bank has de-emphasized user fees in the context of health financing and instead begun to promote risk sharing (World Bank 1997, Dror and Preker 2002, Preker forthcoming).

Waivers and exemptions –the subject of this paper– are mechanisms intended to boost equity in access and in financing of health services when user fees are in place. The pervasive and in places growing presence of user fees in the health sector of developing countries, and the prospect that waivers and exemptions may improve equity in health, are the justification for this research.

1.3 The policy debate about user fees

There have been numerous theoretical and empirical studies about the consequences of user fees for health care in developing countries.[3] Below is discussion on the subject which draws on this literature; it attempts to summarize the major arguments for and against user fees.

Proponents of user fees for health care argue that fee revenue can make public spending more efficient: by improving the availability of complementary inputs such as medicines, user fees help put to better use the otherwise underutilized government-financed health workers and infrastructure. The expansion in output volume that user fees bring about also improves the availability of services to the population. In addition, by financing medicines and other supplies, fees make it possible for government health providers to improve the quality of care (Birdsall 1983, Ainsworth 1984, Attah 1988, Nickson 1990).

Supporters of fees also note that even where government-provided health services are nominally free of charge, in practice not only quality is low but there are hidden payments and additional user costs (such as long waiting and private purchases of medicines) that result in low or unmet demand. As a consequence, low fees for low-quality public services constitute a less desirable policy than some fees for better quality care. Thus, user payments below private sector levels may suffice to make health services acceptable and available to the poor. In many cases, the adoption of fees in public facilities helps to reduce poverty, as

[2] For a discussion of informal fees in the government health sector see Lewis 2001

[3] Wood (1997) offers an excellent annotated bibliography on the subject.

modest public fees substitute much higher payments made by the poor in the private sector (Akin 1986). Evidence from the Dominican Republic and El Salvador indicates that nominally free, low quality government health services face low demand (Bitran 1987, 1989). At the same time, even the poorest pay substantial fees for better or more accessible private care, showing thereby that even the poor often prefer to make some user fee payments rather than consume low quality, free services (see Boxes 1 and 2).

Some also believe that fees convey a signal of higher service value that boosts demand above that achieved when the same services are offered free of charge. Fees are also said to promote a sense of ownership of the services received, thus empowering consumers to demand greater quality and higher provider accountability (Birdsall 1986).

Other authors also allude to the gains in consumption efficiency that user fees for health care may bring about. User fees can deter spurious demand and, by reflecting the true relative costs of production, they may promote more appropriate (i.e., cost-effective) demand patterns along the referral system (de Ferranti 1985, Barnum and Kutzin 1993).

Finally, some authors argue that user fees, when accompanied by a well-functioning system of waivers or exemptions, can help set up a pricing system with which to improve the targeting of public subsidies to the poor (Gertler and Hammer 1997).

Detractors of user fees for health services state that fees do more harm than good. They argue that in many cases where fees are imposed, the extra revenue drawn represents only a small and irrelevant share of total revenue (WHO Study Group 1993); yet at the same time the fees have a substantially detrimental effect on the demand by the poorest (Gilson and Russell 1994). Further, they argue that often fee revenue displaces public subsidies, and therefore does not contribute to expand the revenue base of public providers.

Those opposing fees also question the assertion that fees inhibit spurious demand in the health sector (Abel Smith 1993). They claim that the main problem in the health sector of poor countries is, in fact, under-utilization of medical services, instead of excess use. Rather than deterring spurious demand, fees would inhibit appropriate demand, thus keeping use of preventive and curative services below a social optimum, particularly among the poorest members of society.

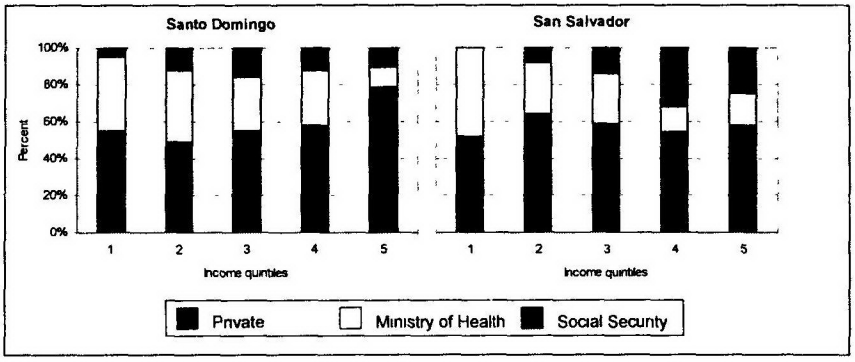
While there is evidence that specific fee structures may improve health care demand patterns –for example higher consultation fees in public hospitals for those bypassing lower-level facilities– existing demand patterns are often said to be a rational response by consumers to poor functioning services at the primary level. Consequently, some argue, a policy that would be more efficient and equitable than bypass fees would be the reallocation of funds away from public hospitals toward the under-funded primary level. This would improve the ability of providers at that level to attract demand and meet needs at a relatively lower cost (Dercon and Ruttens 1998).

Accepting the argument that people are drawn by higher rather than lower (or no) prices for the same service would be questioning the fact that, in general, consumption of goods drops as their price rises. Finally, fees may confer users the right to demand better health services, although if services were improved through higher public funding and offered free of charge, demand would be higher than with the fees.

Box 1. Provider characteristics and consumption of health care services in Santo Domingo (Dominican Republic, 1987) and San Salvador (El Salvador, 1989)

Even where user fees in public facilities are nominally very low or zero, poor quality of care, informal fees, and accessibility problems often limit the use of public services by the poor. At the same time, significant use of subsidized public services by the non-poor reveals a leakage of public subsidies, or the greater ability of the non-poor to pay informal fees in government facilities.

Figure 0 Provider choice, by income quintile



In Santo Domingo and San Salvador, for example, formal user fees in Ministry of Health and Social Security public facilities were insignificant by the late 1980s, and remain so today. The price of a curative medical consultation was 20 to 40 times higher in the private sector than in public facilities. Yet, as is seen Figure 0, in both cities and within all income groups, the majority of individuals obtained care from private providers, despite the relatively much higher private prices. High use of public providers by non-poor individuals (say, from quintiles 3 and up), reveals a significant leakage, or a poor targeting of public subsidies.

As is shown in Table 0, the out-of-pocket payments for private care did not differ greatly by income for the bottom four quintiles in Santo Domingo and for the top four quintiles in San Salvador. As a proportion of household monthly income, however, these payments varied significantly across quintiles, and were heavily regressive.

Table 0 Payments to private health care providers

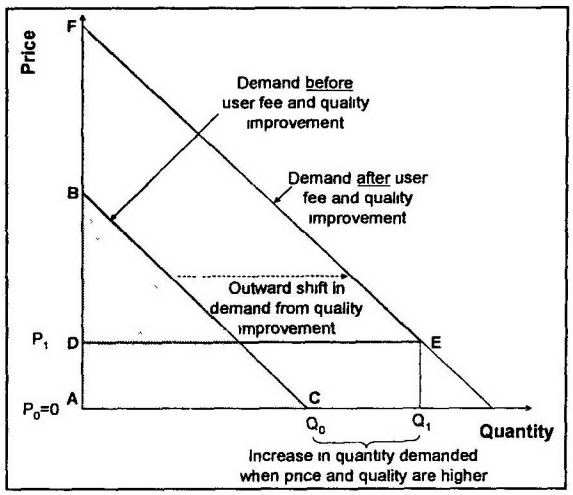
Income quintile	Santo Domingo (1987 pesos)	San Salvador (1989 pesos)
Quintile 1 (poorest)	41	20
Quintile 2	31	18
Quintile 3	44	46
Quintile 4	57	36
Quintile 5 (richest)	82	45

Source Bitran, 1987 and 1989

Box 2. User fees and equity in health

Under the right circumstances, user fees may improve the welfare of the poor. If fees are used to improve quality and if as a result of the quality improvement demand for basic health care by the poor increases, then their welfare unambiguously increases. Newbrander *et al.* (2000) present this issue graphically as in Figure 0. If user-fee proceeds are kept locally by the provider and are used to improve quality –for example, to purchase more and better medicines– then demand for the improved service by the poor may expand. This shift in demand can be high enough such that even with the higher price, quantity demanded (Q_1) is greater than it was when the price was zero and quality was low (Q_0).

Figure 0 Adoption of user fees and quality improvement: Effect on demand



This result requires that cost recovery revenue allow a quality improvement sizable enough to promote a significant shift in demand. Relative to a scenario of no fee and low quality, consumer surplus increases with a higher fee and better quality if the area of the triangle DEF is greater than that of the triangle ABC. The gain in consumer surplus from the user fee policy equals the difference in the area of the two triangles, or DEF-ABC.

Gilson (1997), in her review of the experience with user fees in the health sector in Africa, notes:

> Evidence suggests that if fees are associated with quality improvements, as in community financing schemes of the [Bamako Initiative] type, this offsets their negative impact on utilization, and the introduction of fees plus quality improvements may even generate utilization increases among the poorest.[4]

Consumer surplus does not always increase when user fees are adopted, however, if fee revenue does not permit, or is not used to finance a sizable improvement in quality. In the same review Gilson concludes:

> Countries have not realized many of the theoretical benefits of user fees because of implementation difficulties. Thus presenting case studies of good practice is difficult. Rather, the most discernible lessons pertain to implementation problems and requisites for surmounting them

Thus, these conclusions suggest that user fees should not always be discarded as undesirable, although in practice achieving the potential benefits of user fees is not a trivial problem. There is by now a growing body of literature suggesting that user fees may adversely affect the poor. In health, several studies have shown that demand for health services is more price-elastic, and that the price elasticity of demand –or people's sensitivity to price changes– is higher the lower a person's income. In Côte d'Ivoire, for example, the price elasticity of demand varied between -0.3 for the highest income quintile and -1.8 for the lowest quintile (Gertler and Van der Gaag, 1988). Gertler, Locay and Sanderson (1987) used empirical results from their analysis of health care demand in Peru to suggest that the adoption of a flat consultation user fee in Ministry of Health facilities would promote inequity in access. Demand by the poor would drop significantly in response to a price increase and a simultaneous improvement in quality, while demand by the non-poor would actually increase. Consequently, the welfare of the poor would fall with the flat fee policy and that of the non-poor would go up. These authors recommended the adoption of a system of sliding fees on the basis of ability to pay. There are several other examples of important reductions in access after the introduction of user fees in the health sector.

To sum up, proponents of user fees have argued that these

- Generate additional revenue with which to improve health care quality

[4] Gilson offers these thoughts on the basis of results from an experience in Cameroon, documented by Litvack and Bodart (1993).

- Increase demand for services owing to the improvement in quality
- May reduce out-of-pocket and other costs, even for the poor, by substituting public services sold at relatively modest fees for higher-priced and less accessible private services
- Promote more efficient consumption patterns, by reducing spurious demand and encouraging the use of cost-effective health services
- Encourage patients to exert their right to obtain good quality services and make health workers more accountable to patients
- When combined with a system of waivers and exemptions, serve as an instrument to target public subsidies to the poor and to reduce the leakage of subsidies to the non-poor.

Detractors of user fees argue that these:

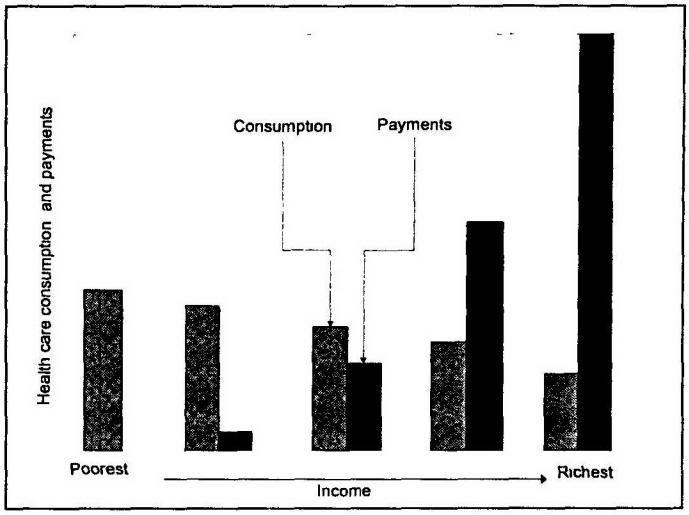
- Are rarely used to achieve significant improvements in quality of care, either because their revenue generating potential is marginal or because fee revenue is not used to financing quality gains.
- Do not curtail spurious demand because in poor countries there is a lack not an excess demand
- Fail to promote cost-effective demand patterns because the government health system fails to make cost-effective services available to users
- Hurt access by the poor, and thus harm equity, because appropriate waivers and exemption systems are seldom implemented.

The opposing views about the desirability of user fees reflect both a difference in ideology as well as diversity in empirical circumstances. For user fees to produce welfare gains for the poor, certain conditions must be met, and the evidence shows that in practice that is not always the case. Still, the adoption of user fees tends to be a policy of choice in most developing countries. This preference seems to respond primarily to practical considerations. Despite their potential adverse effect on equity, user fees are relatively easy to implement and therefore they tend to be preferred over other, harder to adopt policies. Optional policies, but ones that generally are viewed as less viable than user fees, include an increase in government health budgets, additional taxation earmarked for health, the reallocation of government health funds from richer to poorer regions, risk sharing arrangements, the reallocation of public funds from urban hospitals to rural primary level facilities, and the targeting of public health subsidies toward the poor.

1.4 Equity in health

A commonly accepted principle in the context of health services is that equity holds when consumption is in accordance with need and financing is in accordance with ability to pay (Figure 0).[5] Need for health care varies from one individual to another, and to some extent is random and largely unpredictable. Over large population groups, however, health care needs are negatively correlated with income, i.e., poorer individuals tend to have a lower health status and thus need more health care. If health care consumption were in accordance with medical need, one would expect to find that, on a per capita basis, the poor would consume greater amounts of curative health care services than the non-poor. A necessary condition for consumption to match need in health is that access –physical, financial, and cultural– to appropriate services be should favor those with greatest need. In particular, there should be no financial barriers for those wishing to obtain basic health care. For the poor, this means that direct payment for basic services, in the form of medicines or consultation fees should be lower than for the non-poor. Equity in financing holds when those with equal ability to pay make equal payments for basic health care (horizontal equity in financing) and those with greater ability to pay make higher payments (vertical equity in financing). Payments include direct and indirect taxes, payments to social security and to insurance (mainly for health care), prepayments for health care, and all out-of-pocket payments for services.

Figure 0 Equity in the delivery and financing of basic curative health care



1.5 The rationale for waivers and exemptions

For normal goods, such as quality curative health care, demand by the non-poor is greater, on a per capita basis, than demand by the poor. This means that at any given price, such as a flat fee ($P_{flat\text{-}fee}$) in the left panel of Figure 1, the non-poor will demand higher quantities ($Q_{non\text{-}poor}$) than the poor (Q_{poor}). The higher demand by the non-poor responds to their higher income. It also reflects their greater education and the higher associated awareness about the benefits of timely, quality health care. Thus, with a flat fee the poor will be at a relative disadvantage. Sliding fees, or price discrimination, can help solve this problem. To simplify, it is assumed that per capita health care need is equal for the poor and the non- poor. If a sufficiently lower fee can be charged to the poor, such as P_{poor} in the right panel of Figure 1, then their per capita demand will equal that of the non-poor.

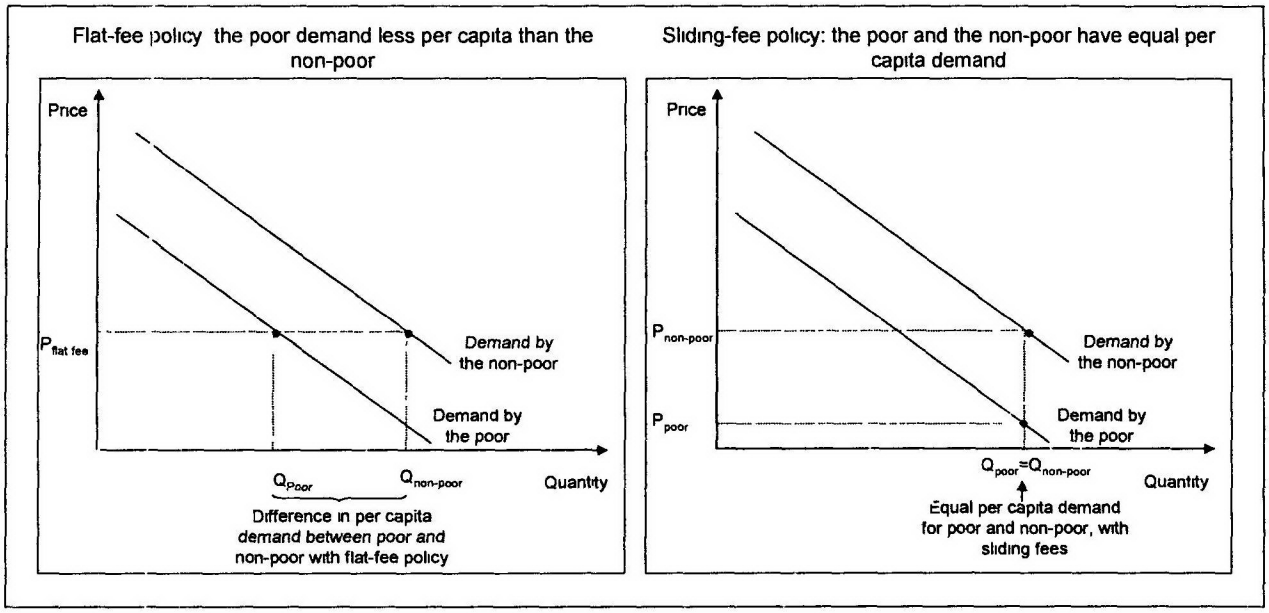
Protecting the poor from user fees entails exactly this kind of mechanism: the structuring of a fee system that promotes equal per capita consumption by the poor and the non-poor.[6] In theory, then, the problem of mitigating the negative consequences of user fees on the poor is solved quite simply. It suffices to know the slope and position of the demand curves, something that can be estimated empirically through household survey data. In practice, however, it is necessary to know who is poor and who is not, and to

[5] This is the principle proposed by van Doorslaer, Wagstaff, and Rutten (eds) (1993).

[6] More generally, with greater per capita health care need by the poor, equitable pricing is one that leads to higher per capita consumption by the poor.

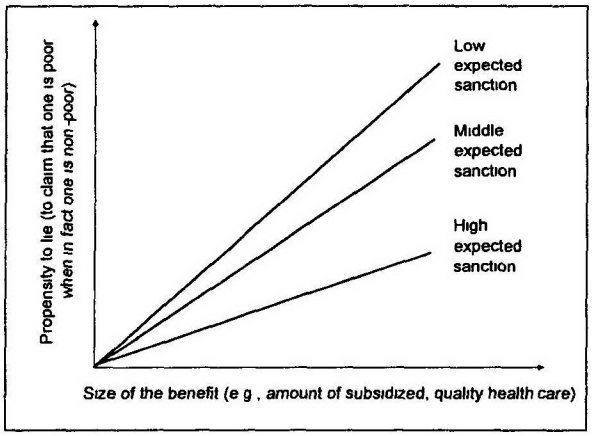
apply differential prices appropriately. Experience shows, alas, that this is an extremely difficult practical problem, with major administrative and logistical requirements. Further, it has been shown that fees are not the only costs faced by potential users of health services. For example, in Cambodia transportation and food costs associated with the use of hospital services can greatly exceed the fees charged by the provider (Hardeman 2001). Thus, while fee exemptions may improve equity in access, to be effective in some cases they must be accompanied by supplementary subsidies to defray additional and significant non-fee costs associated with consumption.

Figure 1 Flat fee and sliding fee policies: Effect on the demand by the poor and the non-poor



A main reason behind the practical difficulty of telling poor from non-poor resides in the incentives facing the non-poor to misreport their identity. If a subsidized service wanted by the poor and the non-poor is made available to all, it will be demanded by both groups. But fiscal constraints in poor countries imply that good quality, fully subsidized health care cannot always be made available to all. There is need to ration the subsidized benefit, and the appropriate policy decision is to keep the non-poor out of the subsidized scheme. Yet if the subsidized services are wanted by all, chances are that the non-poor will seek to misrepresent their status, to be classified as poor and thus obtain the subsidy. This is illustrated in Figure 1. The upward slope of the "propensity to lie" curve shows that the higher the payoff (i.e., the desirability of the subsidized service), the greater the propensity of the non-poor to lie. If it were somehow possible for the provider of the subsidized social service to tell poor from non-poor, for example through a home visit by an incorruptible social worker, and to sanction those lying, then the liars would be facing a known sanction with a known probability. This is not different, conceptually, to the problem of tax evasion. Figure 1 shows that the higher the expected value of the sanction, the lower the propensity of the non-poor to misrepresent their status. Unfortunately there is no such thing as a perfect system of sanctions, and often the optimal policy is the adoption of a combination of incentives –both positive and negative– that lead

Figure 1 Propensity to misrepresent one's economic status as a function of the size of the benefit and the magnitude of the sanction if caught lying



most individuals to behave in accordance with what the managers of social programs expect. Constructing and implementing such a set of incentives requires skill, resources, and information, and constitutes the great challenge of implementing effective and efficient targeted social programs for enhancing the well-being of the poor. The experience of Colombia helps to illustrate the difficulties of avoiding the leakage of subsidies to the non-poor (Box 3).

Box 3. Colombia's experience trying to tell the poor from the non-poor

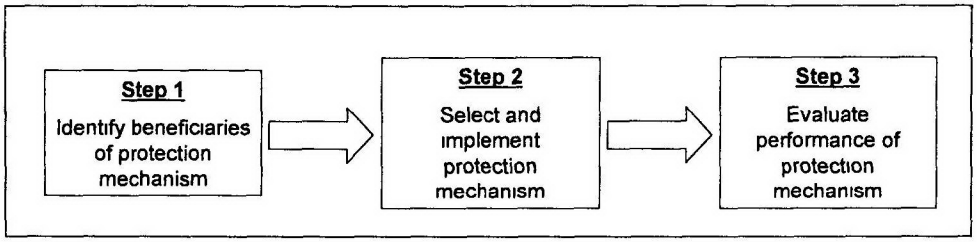
In the mid 1990s Colombia began implementing a major health reform known as Law 100. A main reform aim was achieving an improvement in the targeting of public health subsidies for the poor. To achieve this, municipalities around the country were given resources and were assigned the task of carrying out surveys of all households in their commune to identify those that were poor. Poverty was determined on the basis of various household characteristics, such as quality and size of the construction, number of household members, education levels, and so on

The effort appears largely successful in reaching the poor in those municipalities that have received adequate resources. Yet it has been reported that some families that would otherwise not qualify for the subsidy, rent for a few hours a poor family's house prior to being subject to the test, to qualify as, thus defeating the targeting tool. Also, some individuals subject to assessment by social workers in public hospitals are said to purchase false utility bills on the basis of which hospital staff make a determination about who pays what amount for health services. Falsifiers of bills station themselves in kiosks outside of the hospitals and sell customized bills that make the buyer look poor.

2 Mitigating the effect of fees: Identifying and protecting the poor

Preserving equitable access to health services under a system of user fees can be accomplished in three steps (Figure 2). First, the poor population to receive preferential treatment with respect to user fees must be identified. Second, a protection mechanism must be selected and implemented. Third, to ensure that the protection policy is working adequately, an evaluation of its performance is required. Issues pertaining to these three steps are addressed in this chapter.

Figure 2 Steps in the adoption of pro-poor protection mechanisms



2.1 Identification of beneficiaries of protection mechanisms

There are several methods available to identify those in need of protection and thus to target public subsidies towards those requiring protection. These methods constitute an alternative to the traditional approach of health ministries consisting of universal provision (see Box 5). Which targeting method works best in practice depends on its administrative feasibility and costs, political viability, impact on demand, and other factors (see Box 6).[7] Different authors offer different typologies of targeting methods.[8] The following four categories, depicted in Figure 6, are retained in this paper (for a further description and comparison of these targeting methods see Appendix A):

- Individual identification
- Identification based on group characteristics
- Self-identification
- Self-selection by type of service

(a) Individual identification

With this method, who is entitled or eligible to subsidized health services is determined through an assessment of individual characteristics such as income, health status, behavior, nutritional status, or other criteria. Where ability to pay is the basis for selection, the assessment, which is typically carried out by a

[7] See Sen (1995)

[8] Grosh (1995) recognized three main methods: (1) individual assessment mechanisms, (2) group or geographic targeting, and (3) self-targeting, Glewwe and van der Gaag (1988) and Willis (1993) distinguish between two types of targeting. (1) characteristic targeting (equivalent to Grosh's group targeting), and (2) direct targeting (based on direct individual or household assessment). The World Bank (1993) identifies (1) individual targeting, (2) group targeting, (3) self-targeting, and (4) targeting by type of service.

social worker or a specially trained health worker, may be based on income. But where target beneficiaries work mostly in the informal economy assessing income can in practice be very difficult. In those circumstances, other methods of assessing ability to pay are used, including means tests and proxy means tests (see Willis 1993 and Appendix A).

(b) Identification based on group characteristics

Assessing individual characteristics is not always easy or efficient. For example, suppose that a carefully conducted household survey carried out on a sample of households reveals that the vast majority, say 85 percent, of the inhabitants in a particular geographic region are poor and should be target beneficiaries of a subsidized program. Given the high percentage of target beneficiaries, it may be more efficient to confer protection to all area residents than trying to assess individual characteristics to single out, at a high administrative cost, the non-target population (the non-poor 15 percent). The cost of identifying the poor and the non-poor could exceed the amount of subsidies that would leak out to the non-poor if no targeting effort were in place. In such circumstances, protection is provided at the group level, where a group may be a geographic area known to be predominantly very poor. The leakage to the non-poor is tolerated on efficiency grounds.

(c) Self-identification

In self-identification, no effort is made by the agency granting the protection to identify its recipients because individuals self-select. That is, the health services are provided in such a way that it is mostly those individuals eligible for protection who will come forth and demand the services, whereas non-target persons will mostly demand services elsewhere. For example, this can be achieved by operating a health center in a predominantly poor neighborhood. Most users will be the very poor who inhabit the area whereas fewer non-poor will decide to seek care there, because of stigma, safety concerns, long waiting lines, the lack of amenities, or other reasons. A system designed for self-identification may sometimes impose high private costs to the beneficiaries, such as safety problems and the opportunity cost of the wait.

(d) Self-selection by type of service

The idea here is to offer subsidized services that, for epidemiological, cultural or other reasons, are demanded disproportionately by the poor, or target group, given the special health circumstances and income constraints they face. This is the main idea imbedded in the supply of a basic package of health services in developing countries. The treatment of dehydration from diarrhea, nutritional supplements, and the caring for sexually transmitted diseased and tuberculosis are all examples of services that, if made universally available, would especially benefit the poor.

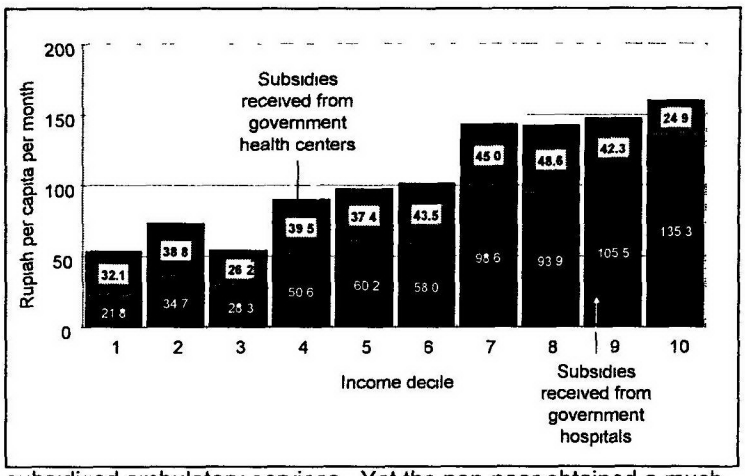
Box 5. Universal versus targeted provision

Despite its theoretical appeal and favorable results around the developing world in other social sectors targeting still remains a relatively infrequent method of directing government health subsidies. In fact, the most widely practiced method in the developing world for reaching the poor with free or subsidized government social services is universal provision, also known as general price subsidies. Universal provision refers to the traditional provider arrangements of national or regional health ministries around the developing world, which offer free or subsidized care to all patients, often regardless of ability to pay (see Figure 3 below). However, van de Walle (1995a) states that

"universal provision is too costly and fails to have much impact on poverty and that targeting can promote cost-effectiveness. So, in the context of pressures to reduce public expenditures, the view has become widespread that targeting allows governments to reduce poverty more effectively and at a lower cost".

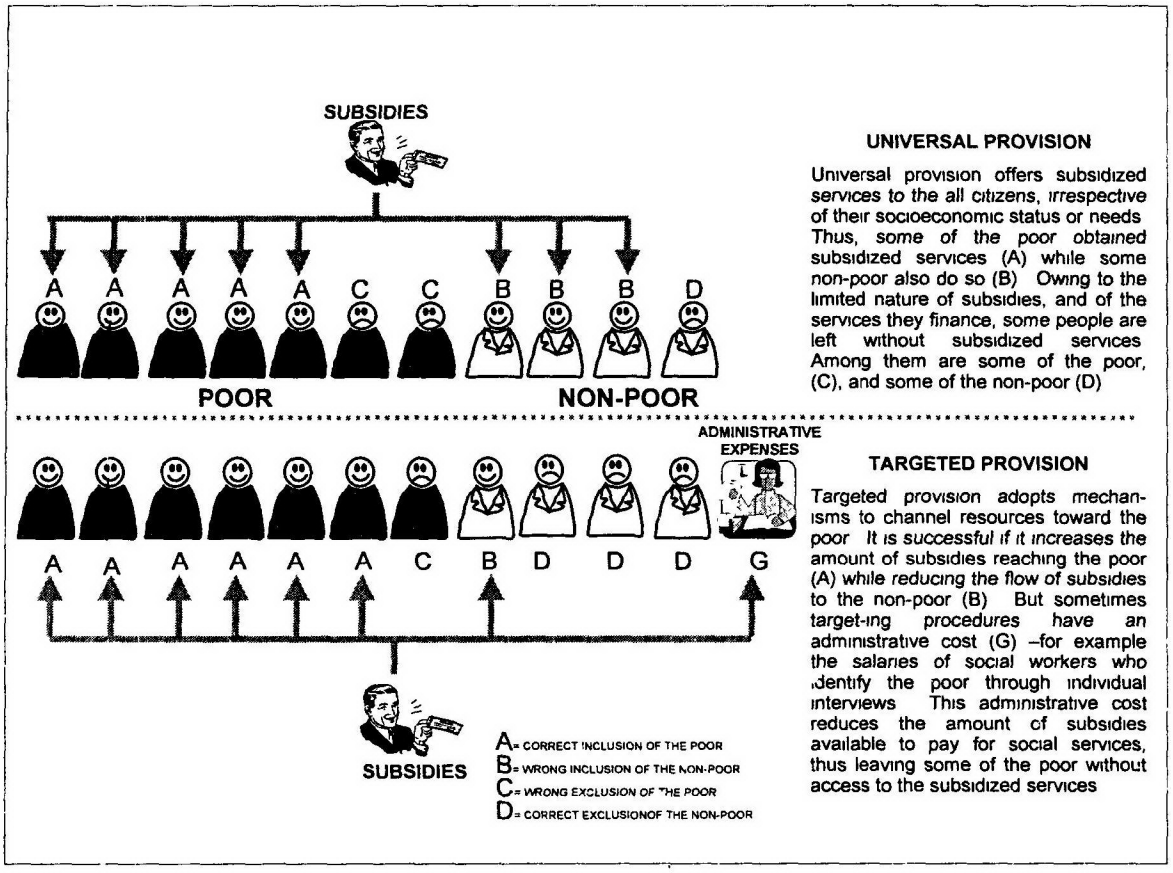
There is ample evidence from the developing world that universal provision of health services leads to a situation where only a share of the public subsidy reaches the poor while a sizable portion of it leaks out to the non-poor. Such was the case in Indonesia in 1997, as is shown in Figure 2. The poor and the non-poor consumed similar amounts of

Figure 2 Indonesia: The allocation of government health care subsidies. 1987



subsidized ambulatory services. Yet the non-poor obtained a much larger share of hospital care than they should (i.e., if all citizens, irrespective of income, were entitled to an equal amount of subsidy). This is attributable to the fact that government hospitals were mostly located in urban areas were most of the non-poor tend to live, and also to the greater ability of the non-poor to secure public subsidies. Recent data from Morocco signal the occurrence of a similar phenomenon there. In Morocco the poor can obtain indigence certificates through their local governments, thereby becoming entitled to free care in government health facilities. The process for the awarding of such certificates, however, is subject to abuse, and thus subsidies appear to be poorly targeted. It is estimated that the richest quintile captures 40 percent of MOH spending while the poorest 40 percent receives less than 20 percent of MOH resources (World Bank 2001b). When there is a leakage there is a case for improving the efficacy of targeting, as this will help to reach the poor with the subsidy and thus exempt them from the fees

Figure 3 Universal vs. targeted provision of health care



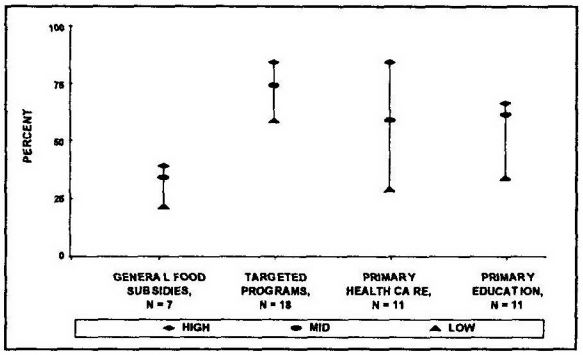
Source: Bitran 2000

Box 6. Targeting effort and incidence: Empirical evidence from Latin America

To assess the tradeoff between administrative costs of targeting and targeting outcomes of government-subsidized social programs, Grosh (1995) carried out an empirical review of 30 such programs in Latin America, including ones in health and education. Most were government programs with national coverage; several of the newest programs were specifically motivated by increases in poverty in the 1980s or by the need to mitigate the social costs of macroeconomic adjustment programs. Seventeen of the programs used individual assessment mechanisms, seven used group or geographic mechanisms, and six were self-targeted (see Figure 6). Grosh's two research questions were (1) which targeting mechanisms provide the best targeting outcomes? And (2) what are their administrative costs?

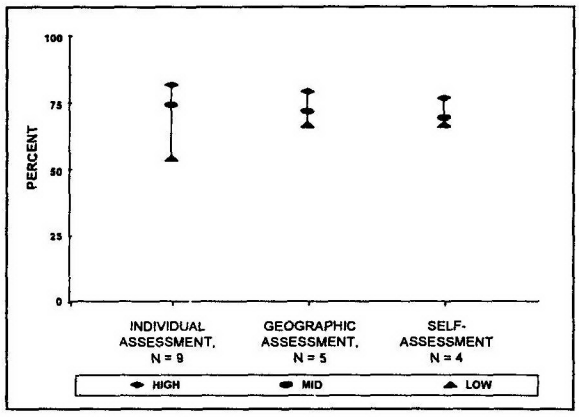
She found that targeted programs had better incidence, i.e., a greater proportion of the subsidy reached the poor than with the untargeted general food price subsidies (Figure 4). The best performing general food price subsidy program (that is, the least regressive of them), delivered 37 percent of the subsidy to the poorest 40 percent of all households. The worst performer of the targeted programs (i.e., the least progressive of them) channeled 59 percent of the benefits to the poorest 40 percent of the population. On average, 33 percent of the benefits of general food price subsidies went to the poorest two quintiles, while for the targeted programs the figure was 72 percent.

Figure 4 Share of benefits accruing to poorest 40 percent, by sector



Grosh also found that different targeting mechanisms produced rather similar outcomes in terms of incidence of benefits, as is shown in Figure 5. Individual assessment mechanisms achieved a median of benefits going to the poorest 2 quintiles of 73 percent. The equivalent figure for geographic targeting mechanisms was 72 percent, while for self-targeting it was 71 percent. In addition, there were only minor differences in the performance of these different mechanisms among the various countries in the sample.

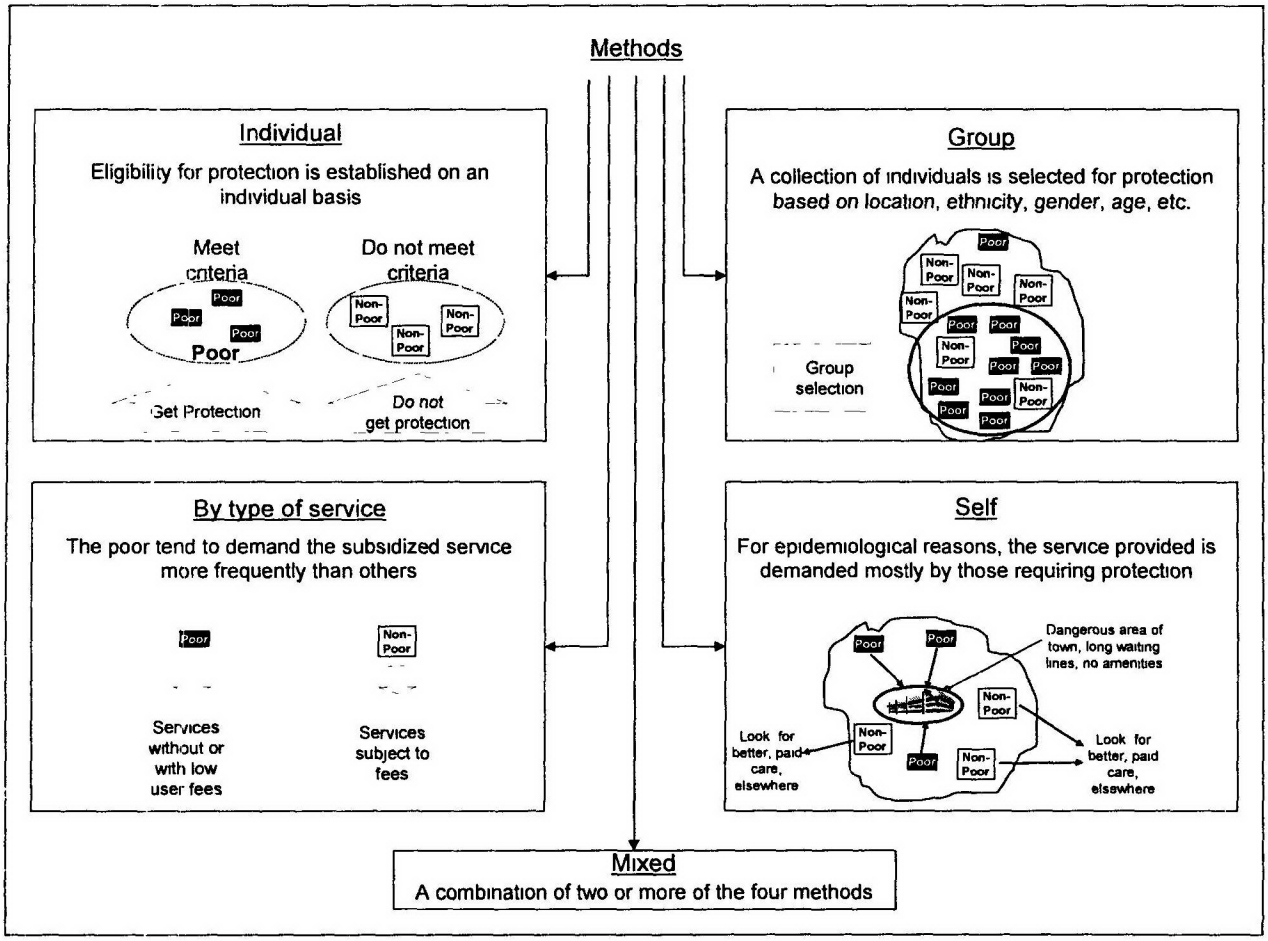
Figure 5 Share of benefits accruing to the poorest 40 percent, by targeting mechanism



Although targeted programs had a much better incidence that untargeted ones, Grosh had to examine the relative costs of both types of program to be able to infer their relative merits.

The median cost of targeting as a share of total program costs was 6 percent for programs relying on self-targeting, 7 percent for those using geographic assessment, and 9 percent for programs that relied on individual assessment. Not all program administrative costs are associated with the actual effort of targeting, however. Still, targeting costs (beneficiary identification, or screening) were relatively modest, accounting for a share of total program costs that varied between 0.4 percent and 8 percent. Finally, Grosh examined whether programs that succeeded in channeling a greater proportion of benefits to the poorer income groups cost more administratively. She concluded that was no clear connection between targeting results and administrative costs.

Figure 6 Identification methods

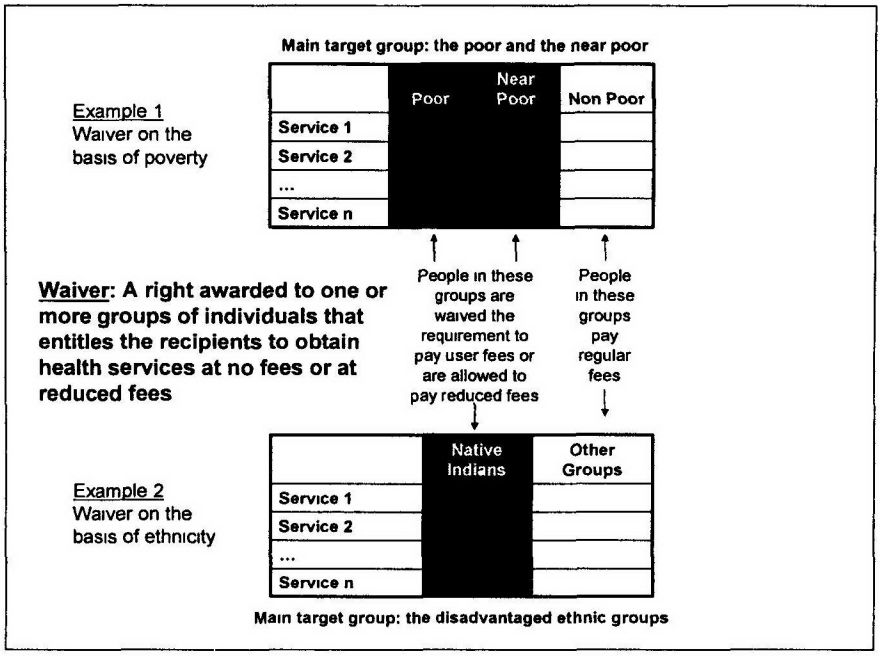


2.2 Protection mechanisms: Waivers, exemptions, and design features

(a) Waivers

A waiver is a right conferred to an individual that entitles him or her to obtain health services in certain health facilities at no direct charge or at a reduced price (see Figure 7). The subjects of waivers are individuals The existence of waivers in a health system implies that the system will discriminate between waiver holders and the rest of the population. By reducing the out-of-pocket cost of care to beneficiaries, waivers seek to improve both equity in access and equity in financing of health services.

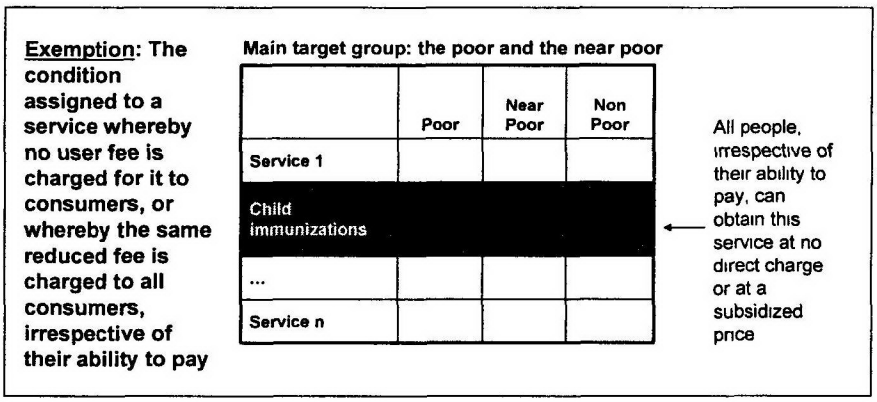
Figure 7 Waiver



(b) Exemptions

Whereas waivers are associated to certain individuals, exemptions are associated to certain services. An exempt service is one that is to be provided at no charge (or at a reduced price) to patients. In its broadest form, a waiver entitles its holder to receive all services at no direct charge; in its broadest form, an exemption implies that the exempt service will be provided to all individuals at no charge. Exemptions are adopted mainly for efficiency reasons and thus seek to correct some market failures. Their purpose is to promote the consumption of specific health services, including those whose benefits are under-valued by the population, those that have externalities, or those that are pure public goods. Vaccinations are a typical example of an exemption whose purpose is to correct information failures (uneducated people tend to fear vaccines or under-value their benefits) and to promote consumption for a medical service that has an externality.

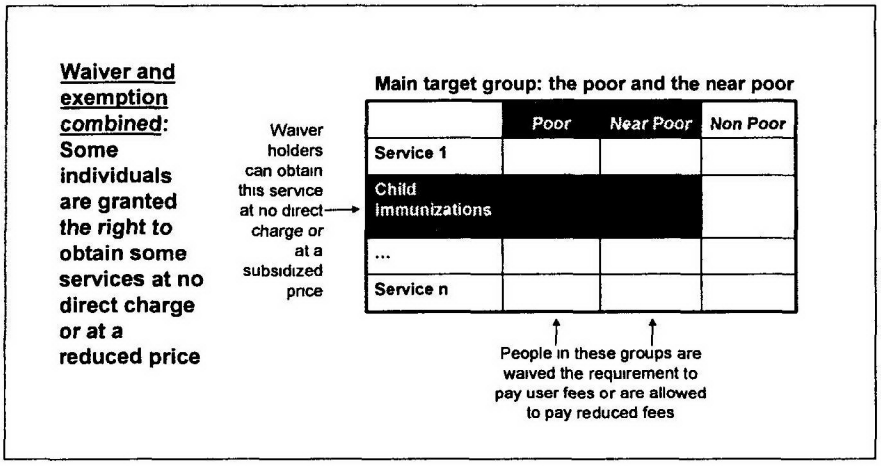
Figure 8 Exemption



(c) Waivers and exemptions combined

Waivers and exemptions may be combined, thus setting a system where certain individuals are entitled to obtain certain health services for free or with a subsidy (Figure 9).

Figure 9 Waiver and exemption combined



(d) Design features for waivers and exemptions

Designing and implementing a system of exemptions is considerably simpler than doing so with a system of waivers. A system of exemptions requires one initial basic decision, namely determining which services will be offered for free or at reduced prices. Such a determination may respond to specific economic and medical criteria, such as those mentioned in the preceding paragraph. Once that decision has been made, managing the system of exemptions tends to be administratively simpler than managing a system of waivers. This relative simplicity stems from the fact that a system of exemptions imposes no need for identification of beneficiaries –a major hurdle in a system of waivers. Adopting exemptions thus can be as easy as imparting the order among the concerned providers that the services to be exempted are to be offered at no charge to all customers. Most developing countries have systems of exemptions, and these function quite well and impose only minor administrative demands. For example, in some countries some primary and preventive services, such as child immunizations, are offered for free in all public facilities and to all patients country-wide.

Aside from deciding which services are to be waived, designing a system of exemptions entails also determining who will deliver the exempt services –it can be public, private for profit, and private non-profit providers– and how the costs of delivery will be financed by the payer of services. A common situation is that the providers of exempt services are all public and their funding comes from their fixed monthly budget, in which case the payment system remains easy to manage. Universal provision of health services free of charge to all in government facilities that are financed through historic budgets is a generalized system of exemptions. In some situations, the funding of exempt services may come from payments made by the financing agency to the provider of exempt services on the basis of a previously agreed on payment mechanism, in which case management may become more complex. Capitation requires that a list of registered beneficiaries be handed by the provider to the payer; fee-for-service requires that periodic invoices be submitted by the provider to the payer; and so on. Brazil's *Sistema Único de Saúde* (SUS) offers a large set of exempt services to Brazil's population through a nationwide network of public and private providers, to which it has to pay for exempt services on the basis of diverse payment systems.

To sum up, designing and adopting a system of exemptions is relative simple because, unlike a system of waivers, it does not impose the need to identify individual beneficiaries. A system of exemptions shares with a system of waivers the administrative requirement that a payment system be in place to defray the costs of the services that are offered at reduced prices or for free.

Designing and implementing a system of waivers is, in contrast, considerably more complex because it imposes the adoption of different rules for different individuals. The need to classify individuals as beneficiaries and non-beneficiaries of waivers, along with the need to identify them at the point of service imposes major administrative demands on the health system. Here, many design options arise and these impose a series of consequences for the health system, in terms of incidence of benefits and administrative costs. Table 2 outlines in the form of questions the design options that the policymaker wishing to adopt a system of waivers faces. The last two columns of the table show that some questions apply both to waivers and exemptions, whereas others apply only to one or the other system. The design options of Table 2 have been classified in four distinct categories, as follows:

- **Resource availability:** How much money will be available to finance waivers and exemptions? Often, policymakers adopts waiver and exemption systems without making the necessary provisions to ensure that there is a match between the total production cost of the services to be waived or exempted and the funds available to finance the policy. Achieving such a match requires that estimates be available about the total beneficiary population, their demand for the waived or exempt services, and the cost of those services.

- **General design and implementation:** Adopting a system of waivers or exemptions involves a series of design issues. One central issue is the revision of the existing system of user fees with the aim of furthering the objectives of the waiver or exemption system. This means that user fees must be in place for those with an ability to pay (patients not entitled to waivers must pay the ongoing fee) and that only exempt services must be provided free of charge (non-exempt services are charged to patients). Revising the user fee policy is important whether the facility is allowed to retain the revenue locally or whether user fee proceeds must be returned to a regional or central authority; in either case user fee revenue will eventually ease the fiscal impact of a waiver or exemption policy. There are other key design and implementation issues and these are outlined in Table 2. They involve determining which services are to be exempted or which individuals are to be waived, the duration of the exemption or waiver, choosing an identification (or targeting) instrument, and deciding who will administer the system, among other things.

- **Supply-side design and implementation features:** As already noted, the particular design of the waiver or exemption system conveys specific incentives to the providers of services. A good design is one which confers incentives leading providers to behave in ways that further the objectives of the waiver or exemption system. That is, a good design leads to the provision of the appropriate amount of waivers to the target beneficiaries, the denial of waivers to non-beneficiaries, and the provision of the right kinds of exemptions. Clear and realistic definitions of beneficiaries, and appropriate dissemination of information about procedures, are factors that contribute to the success of a waiver system. In contrast, a faulty design may defeat the waiver or exemption policy. For example, an ambiguous or complex definition of a beneficiary in a waiver system can lead to failure. Examples of successful and unsuccessful experiences are provided in Chapter 3.

- **Demand-side side design and implementation features:** Waivers and exemption systems confer incentives to consumers, or should be accompanied by incentives which must be aligned with the aims of the systems. For instance, where exemptions exist for some services, such as institutional deliveries, appropriate information must be disseminated among pregnant women, often with the help of promoters and community leaders, to foster an understanding about the health benefits of institutional deliveries and, thus, to promote demand for the exempt service. Simply exempting institutional deliveries may in some circumstances be an insufficient incentive to

boost demand for this service. As regards waivers, a system which provides free curative health services to holders of an indigence card may fail to draw target beneficiaries if access costs other than the user fee (e.g., travel costs and the opportunity cost of time) are high. In such a case, the waiver system may also have to envision funds and a mechanism for defraying those other consumption costs of target patients.

As already noted, relative to exemptions waivers have the added difficulty that they are awarded on the basis on personal characteristics. Therefore they require an administration for the waiver process and the adoption of decisions regarding the awarding of waivers. These are discussed next.

Waivers: Design and implementation issues

Who grants waivers? Whose responsibility is it to identify those to be protected: An epidemiologist with the MOH, a specialist with the National Statistical Institute, a social worker with the agency delivering the social services, or a doctor working in the hospital? In El Salvador, MOH officials determine on the basis of a broad set of poverty and health status indicators which health districts are entitled to a free package of health services. In Zaire's health zones, it is the nurse running the health center who makes the determination about who is fully or partially exempted from fees. Thus, waivers may be granted by a special administrative body that is separate from a health facility, in which case waiver beneficiaries must carry some kind of identification that distinguishes them from non-beneficiaries when demanding health services. Or waivers may be provided health facility staff and in that case identification may be unnecessary. When an entity other than the health provider grants waivers a conflict of interest presents itself if the cost of the waived services is not faced entirely by the entity issuing the waiver and if the waiving agency is rewarded on the basis of the volume of waivers granted. In Cambodia, for example, some equity funds granting waivers do not have to reimburse health providers for the full cost of waived services and therefore they may over-provide waivers. Suriname's Ministry of Social Affairs used to over-provide waivers because it did not face the full cost of waived services, and its staff derived personal benefits from issuing waivers. When that situation changed, and MSA begun to face the full cost of health care, the agency became much more stringent and reduced the number of waivers granted.

Are waivers supply- or demand-driven? Does the identification system actively search for prospective beneficiaries, or does it passively wait for them to show up and request protection? In Suriname, the Ministry of Social Affairs (MSA) issues MSA cards that exempt cardholders from the payment of user fees in government hospitals. To obtain the card individuals must apply as the MSA does not actively search for potential beneficiaries. In Colombia, in contrast, the Beneficiary Identification System (SISBEN) run by municipalities actively interviews all households in their jurisdiction, and selects the ones to enter the Subsidized Regime. All beneficiaries of the Subsidized Regime are automatically entitled to a government subsidy that covers their health insurance premium.

When are waivers granted? Waivers may be provided at different moments in time. For example, they may be distributed to beneficiaries in their homes or in the premises of an administrative agency when individuals are in no imminent need for health services. Beneficiaries thus carry the waiver document with them in case they will need to produce it at a health facility in the future, should the need for health services arise. Chile's National Health Fund (FONASA) provides waiver cards to the indigent and these present the cards to public providers when demanding health services, thus receiving free care. Alternatively, waivers may be provided by health facility staff or by a special agency at the time when health services are demanded. Such is the case in Cambodia's Takeo Hospital, where specially trained health staff subject waiver applicants to the means test on site, asking them to fill out a form answering various questions about their employment, house characteristics, number and age of household members, possession of vehicles and other durable assets, and ownership of domestic animals. Waiver granting staff thus compute a score on the basis of the answers given and provide a waiver if the score is below a certain threshold.

When a waiver is provided –ex ante or at the time the services are needed– may affect health care seeking behavior if the waiver application costs, also known as "participation costs", are high or if prospective applicants are uncertain about their chances of getting a waiver. In situations where waivers are granted ex-ante, waiver beneficiaries know with certainty that if they demand health services in certain locations they will be entitled to free care. Thus, their demand for care will not be diminished by the prospect of an out-of-pocket payment. In contrast, in situations where a waiver determination is made each time a health service is demanded, some prospective patients may get discouraged from seeking care if waiver participation costs are high or if their perceived likelihood of getting a waiver is uncertain. Participation costs refer to the economic, time, and other costs that an individual has to incur to apply for a waiver. For example, Table 1 presents some of the requirements set forth by a government agency in a Latin American country to grant waiver cards for health care or to provide free care to those not entitled to a waiver card. This is an example of a waiver process with high participation costs. If the waiver granting entity is known by the target population to always awards waivers to applicants, as was the case of Suriname's Ministry of Social Affairs,[9] then when the waiver is provided –ex ante or at the time the services are needed– makes no difference in terms of people's health care seeking behavior. Those needing care will demand services equally, whether they already have a waiver card in their possession of whether they do not have a card but are certain that they will obtain free care.

Table 1 Requirements to obtain health services waiver: example from Latin America

Individuals entitled to a waiver health card: requirements to obtain the card	**Dependent Worker Indefinite Contract**	**Dependent Worker Temporary Contract**	**Retired**
Application form	Yes	Yes	Yes
Photocopy of work contract	Yes	Yes	-
Contribution certificate	Yes, last payment	Yes, payments for at least 6 months	No, but must present pension payment coupon
Personal national identification card	Yes	Yes	Yes
Family dependent's national identification card	Yes	Yes	Yes
Certificate of dependence	Yes, from birth registry	Yes, from birth registry	Yes, from pension fund manager
Duration of waiver	2 years	12 months	Indefinite
Individuals not entitled to a waiver health card: requirements to obtain free health services	**Independent Worker**	**Unemployed Worker**	**Indigent**
Certificate of indigence	No	No	Yes
Contribution certificate	Yes, payments for at least 6 months	-	-
Personal national identification card	Yes	Yes	Yes
Family dependent's national identification card	Yes	Yes	Yes
Certificate of dependence	-	Yes, pension fund manager	-
Pension fund affiliation certificate	Yes	-	-
Other	-	Unemployment subsidy card	Health condition certificate from the health service or municipality

Eligibility requirements. What information is required for identification: data from a household survey, individual tax forms, proof of income, and assessment of assets or enrollment in other social protection programs? If administrative requirements for identification are major (as in the case of Kenya described in Chapter 3) then participation costs might be too high, thus leading to a modest level of identification (under-coverage). If, on the other hand, the requirements are too few, then leakage may be high. Eligibility requirements may be as simple as responding to and passing an on-site interview to a longer and more demanding process such as the one described in Table 1. In an effort to increase precision, those designing and managing eligibility processes tend to adopt complex, demanding, and time

[9]. Giedion, Bitran, and Muñoz 2002

consuming tests and interviews. These raise the participation cost of waivers and thus discourage some prospective applicants. Those who choose to comply may be lower-income persons whose opportunity cost is lower than the value of the benefits that the waiver carries, but such cumbersome procedures may also discourage application from some low income individuals wary of questions and bureaucracy. Finding the right balance between the stringency of a means test for waivers and the coverage of the waiver program (percentage of the poor who actually benefit from waivers) is a major challenge for policymakers.

Duration of waiver Waivers can be temporary or permanent. The most short-lived waiver is that provided for a specific service within a health facility. For example, a patient who is hospitalized may have to request a waiver for the payment of a laboratory exam, and then again, during the same hospitalization, he or she may have to apply repeatedly for waivers on other medical procedures, such as the surgical fees or the medicines received. Such an atomized waiver procedure, illustrated in an example in Chapter 3, which tends to cause confusion and frustration among patients, is common in those health facilities where there are separate medical departments, each with its own budget and waiver policy. A somewhat broader waiver but one that is still short term in nature is that which is provided for the treatment of a specific illness episode, covering all inputs and services given to the patient during that episode, but expiring once the treatment is completed. Prospective patients must reapply for a waiver in the future to treat new illness episodes. Long-term waivers are those awarded to individuals with a validity of one year or more, including those that are indefinite. In some countries the handicapped or the elderly are entitled to permanent waivers in certain health facilities.

Extent of waiver. Waivers may be full or partial. A full waiver entitles its beneficiary to obtain for free the services it covers; a partial waiver may require of the applicant a partial payment, that is, one below the full price. Chile's National Health Fund confers full waivers to indigent beneficiaries, but has a sliding fee scale for non-indigent beneficiaries, thus granting a price subsidy that decreases with income. Thailand's former low income card system (LICS) fully exempted the poor from payment in health facilities.

Table 2 Waivers and exemptions: design and implementation issues

	Waiver	Exemption
Resource availability		
What amount of resources is available to finance waivers/exemptions?	X	X
General design and implementation		
Is user fee policy effectively used to further objectives of waivers/exemptions policy?	X	X
Which services are waived or exempted?	X	X
Who is entitled to a waiver?	X	
At which level of health system is waiver/exemption provided?	X	X
On what basis is waiver provided (individual assessment, group, self-selection)?	X	
How well informed are implementers about waiver/exemption policy?	X	X
If waiver provided on individual basis, what kind individual assessment method is used (means test, proxy means test)?	X	
Who provides waivers?	X	
Is waiver provided on an individual or a family basis?	X	
Is a system of identification cards used?	X	
Are identification criteria revised regularly?	X	
How long is waiver good for?	X	
Supply-side design and implementation features		
Are providers compensated for revenue forgone?	X	X
What payment mechanism is used to compensate providers?	X	X

Table 2 Waivers and exemptions: design and implementation issues

What is the significance of compensation relative to customary fees and to actual cost?	X	X
How timely is compensation?	X	X
Does compensation cover administrative costs?	X	X
Are compensation amounts revised regularly to keep up with costs?	X	X
Is user fee revenue kept at facility?	X	X
Is staff income tied to user fee revenue?	X	X
Are records kept on user fee revenue and on waivers and exemptions provided?	X	X
Demand-side design and implementation features		
How well disseminated is waiver/exemption policy?	X	X
Do agents responsible for providing waivers actively screen for potential beneficiaries or do they passively wait for them?	X	
When is waiver provided ex-ante, when service is demanded, or ex-post?	X	
How important is social stigma?	X	X
Are beneficiaries discriminated (i e , are they mistreated or treated differently)?	X	X
How accessible are services for non-beneficiaries?	X	X
How well informed are potential beneficiaries about policy?	X	X
What is the magnitude of individual access costs to the system?	X	X
Does program finance all or part of patients' access costs?	X	X
What penalties are imposed on those cheating the system?	X	

Reach. A waiver may be provided to some members of the household or to all. Typically the latter is more common, but there are several examples of waiver systems which are provided at the individual level –for example a waiver covering a single mother and her child, both of whom live with the mother's parents, but where these do not qualify for a waiver.

Who provides program benefits? Do protection mechanisms restrict the set of providers where program benefits are delivered or can beneficiaries freely select their providers? In Colombia the beneficiaries of the Subsidized Regime get a demand subsidy from the municipal government that allows them to enroll with a public or with a private health insurer of their choice. But they can obtain health services only from those providers that have a contract agreement with their insurer. Chile's National Health Fund entitles its higher income beneficiaries to a partial waiver for private health services. Beneficiaries can freely select the provider from a broad list established by FONASA. In Honduras, beneficiaries of the Maternal and Child Food Coupon program can receive health benefits financed by the program only from public facilities, but they can redeem the food coupon in any private grocery store.

Financing of waived benefits. Up to here all issues in this section have dealt with the process of identifying beneficiaries and managing the waiver process. A distinct but equally critical component of a waiver system is its financing. A successful waiver program requires that the value of the services waived equal the funding available for the program. Such a balance is seldom contemplated in the design of a waiver policy and thus rarely holds. As already noted, achieving that balance requires knowledge about the number of beneficiaries of the waiver program, their demand for the waived services, and the production cost of the services. These information requirements increase with the number and complexity of the services included in the waiver program. Lack of clarity about funding needs for a waiver program often means that financing is insufficient and that the rationing of services emerges as the de facto tool which imposes a balance. For example, Guatemala's Coverage Extension Program implemented in the late 1990s sought to deliver about 15 different kinds of preventive and primary health services free of charge to rural poor populations through provision contracts with NGOs. Poor prior knowledge about actual delivery costs meant that the program was underfinanced and as a consequence only few of the services contained in the basic package of 15 interventions were actually delivered to the

target population. Carrying out a thorough analysis of financing needs for a waiver program is a key to its success.

Provider compensation. Does the provider of services get financial compensation from the program for the delivery of subsidized services to beneficiaries of protection programs? Or does it have to collect revenue from non-program customers to cover program costs? Or does it have to ration delivery and limit free care to live with its limited existing budget? Many waiver programs fail because they do not fully compensate providers for the revenue they forego by delivering free services to program beneficiaries (see examples in Chapter 3). Compensation obviously requires knowledge about production costs and the existence of a payment system through which the waiver program channels funds to the provider. Which payment system is chosen has implications for the performance of the waiver program. For example, if fee-for-service is selected, and if the fee reflects full marginal cost, then the provider will have an incentive to provide free care to beneficiaries. In an attempt to boost revenue, it may also attempt to give free care to non-beneficiaries, if the reimbursement is higher than the regular price, and to bill the financing agency for it. To avoid cost escalation, the financing agency may have to impose a budget ceiling for the payment of waived services. Capitation, in contrast, consists of the periodic payment to the provider of a fixed amount of money for each registered beneficiary of the waiver program. Since this payment is not tied to the volume of services actually delivered, the incentive of the provider may be to under-provide free care –just the opposite effect of fee-for-service payment. The selection of an appropriate payment system has been the subject of a recent debate in the context of Cambodia's equity funds (Knowles 2001; Bitran 2002).

Protection with specific benefits versus unconditioned cash transfers Do the benefits of protection programs come in the form of free or subsidized health services, or do they come in the form of income supplements –cash– which beneficiaries can use freely, on health services or on other consumption?

2.3 Performance of protection mechanisms

Assessing the performance of a protection mechanism should be an integral part of a poor-protection policy. Questions to be asked include the following (see Table 3): Are the intended beneficiaries actually protected; has there been an increase in their use of health care services; are some non-poor inappropriately benefiting from the protection? What is the actual administrative cost of the protection mechanism? How efficient is the protection mechanism, in terms of the ratio between the protection granted and the administrative costs of this protection? What are the outcomes of the program, in terms of better health status? Below is a definition of concepts related to performance and a discussion of performance measurement issues.

Table 3 Monitoring and evaluation of waiver and exemption systems

Monitoring and evaluation issues		
Are performance evaluations conducted regularly or sporadically?	X	X
Is provider compensation system working effectively and is compensation amount in accordance with the actual cost of service?	X	X
Are prospective beneficiaries actually waived?	X	
Do waived beneficiaries make greater use of services than poor, non-waived individuals?	X	
Do the beneficiaries of waivers get financial protection?	X	
Is there an increase in utilization of exempt services?		X

(a) Errors and accuracy in beneficiary identification

A successful beneficiary identification program is one that identifies those in need of protection with precision, neither missing any of those in the target group nor allowing any benefits to go to those outside

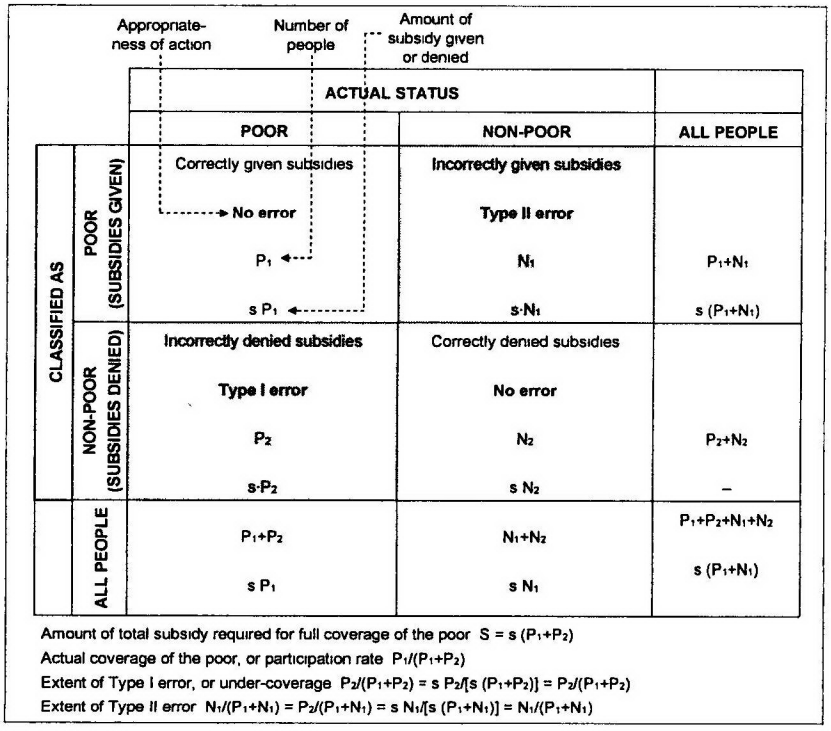
of it. Identification is seldom perfect. Those running a beneficiary identification program can make the two following possible types of errors (it is assumed that those needing protection are the poor, as will almost always be the case for social programs such as basic health care):

To classify as non-poor someone who is truly poor. This means denying protection to someone who deserves or requires it. This kind of inaccuracy is called a *Type I error* (also known as a false negative) or "under-coverage". Type I errors can arise from an overly stringent screening mechanism, from the reluctance of potential beneficiaries to be tagged as poor, or from lack of knowledge among prospective beneficiaries about the program. Reducing Type I errors promotes equity by improving access to social services by the poor.

To classify as poor someone who is not poor. This implies that protection is awarded to non-target individuals. This type of mistake is generally referred to as a *Type II error* (also known as a false positive), and more commonly called "leakage".

Figure 10 summarizes the four possible outcomes of a beneficiary identification effort. The accuracy of the method can be calculated in terms of Type I and Type II errors. Both types of error can be expressed either as the number of misclassified people or as amounts of money over or under spent. The extent of Type I error or under-coverage is measured by dividing the number of poor wrongly excluded from the benefits by the total number of poor. It can also be measured by dividing the value of benefits wrongly denied by the amount of money required to provide benefits to all of the poor. Grosh (1992a) states "The complement of under-coverage is coverage, or the percent of those who ought to be served who are served. This is sometimes called the participation rate". Type II error or leakage is measured by dividing the number of non-poor beneficiaries by the total number of beneficiaries, or the value of benefits wrongly awarded to the non-poor (upper right quadrant) by the total value of benefits (upper left and right quadrants).

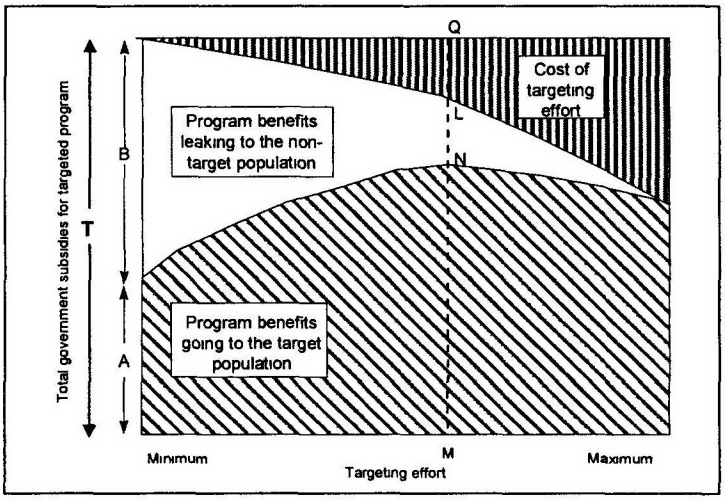
Figure 10 Identification errors



(b) Accuracy-cost tradeoff in beneficiary identification

In principle. one would like the identification effort to be as precise as possible, ideally reducing leakages to zero while reaching all target beneficiaries. In practice, however, this is seldom possible. The more accurate a beneficiary identification effort is, the higher its coverage (smallest Type I error) and the lower its leakage (minimal Type II error). Achieving a high degree of accuracy however requires costly information gathering and compliance efforts to identify intended beneficiaries and exclude the rest.

Figure 10 Tradeoff between accuracy and cost of targeting



This tradeoff between the identification effort and the incidence of the program is illustrated in Figure 10.[10] Consider a subsidized health program, worth $T million, delivered without any targeting effort. Universal, free-of-direct-charge provision of government-financed services is an example. In the absence of a targeting effort, part of the subsidy, or the amount A in the figure, will reach the intended population group (defined, for example, as the poorest 40 percent of the population); and, because of a lack of targeting, part of the subsidy, equal to Be, will leak out to the non-poor, such that A+B=T.

If an effort were made to identify target beneficiaries –for example those below a certain income or socioeconomic status threshold– the amount of subsidy reaching the poor would increase from its original value of A, while the subsidies reaching the non-poor would decrease from the initial value of B. But at the same time, a new cost, the administrative cost of the beneficiary identification program, begins to eat up part of the total subsidy amount available. For a while, the greater the identification effort, the larger the volume of subsidies that reaches the poor, the smaller the share of the subsidy that filters to the non-poor, and the higher the share of the total subsidy that is devoted to the identification effort. If the effort were maximum (right-hand side of the figure), that is if somehow program personnel were able to identify with precision all target and non-target beneficiaries, then there would no longer be any leakage of program resources: subsidies would be divided into benefits going to target beneficiaries and costs of the targeting effort.

But with a decreasing marginal return of identification, engaging in the highest possible identification effort clearly would not be optimal, because the share of program benefits going to the poor would not be maximal. A smaller beneficiary identification effort, or optimum, denoted by M in the figure, would be preferred: a maximum of benefits equal to the distance MN would go the to poor, a total of resources equal to NL would leak to the non-poor, and an amount equal to LQ would be eaten up by the identification effort.[11]

Both accuracy and costs determine the efficiency of beneficiary identification. Thus, the most accurate strategy is not necessarily the most efficient because it might entail high costs. The "output" to be produced as efficiently as possible is defined by the policy objective (for example, providing the biggest transfer to the poor). In this case, the most efficient targeting strategy is the one that transfers the largest

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[10] This scheme has been suggested by Willis (1993)

[11] . It has been suggested that to gain political support for a targeted program sometimes it is necessary to allow some leakage.

portion of a fixed budget to the poor. This requires minimizing the sum of targeting costs and costs in the form of leakage to the non-poor.

3 Empirical evidence on protection mechanisms

3.1 Introduction

Chapter 1 was a conceptual discussion of user fees in health and their likely effect on the poor. Chapter 2 examined theoretical ways of preserving equitable access to health care when user fees are in place. This third chapter offers information from seven countries on their actual experience with protection mechanisms. Criteria for choosing a case include novelty, success or failure of protection mechanisms, diversity in socioeconomic circumstances, and availability of data. Gathering sufficient information to write a case was a demanding task, as sources are dispersed and often informal. Most cases were written on the basis of multiple sources, written and oral. Table 4 presents a list of selected indicators for case study countries, with the countries organized in ascending order of purchase-power-adjusted per capita GDP (1997). The cases that follow are presented in the same order, each with the following common structure: (a) context; (b) user fee policies; (c) protection mechanisms; (d) results (e) lessons learned for case study countries and for others wishing to implement protection mechanisms.

Table 4 Selected indicators, case study countries*

	Kenya	Cambodia	Ghana	Zimbabwe	Indonesia	Thailand	Chile
Demographic indicators							
Total population 2001 (millions)	29 8	13 1	19 9	11 4	206 1	62 4	15 4
Life expectancy at birth 1999 (years)	47 7	53 7	57 9	40 4	65.7	68.6	75 5
Urban population 1999 (percent)	32 2	15 6	37 9	34 6	39.8	21 3	85 4
Economic indicators							
GDP growth rate 1997 (percent)	2.1	1 0	4 2	2 8	4.7	-1.5	7 4
Per capita GDP 1997 (1995 PPP $)	1,020	1,330	1,760	2,680	3,130	6,440	8,440
Poverty indicators							
Year	1992	1999	1992	1990	1999	1998	1994
Population under poverty line, Total (percent)	42 0	35 9	31 4	25 5	23 4	12 8	23 2
Rural	46 9	25 2	34 3	31 0	19 5	17 2	21 8
Urban	29 3	40.0	26 7	10.0	26 1	1 5	30 6
Health expenditure							
Per capita health expenditure 1997 (current PPP $)	81	96	54	186	55	347	533
Private health expenditure as percentage of total 1997	35 9	90 6	53	38 2	47 4	65.4	48 6
Structure of health expenditure 1997 (percent of GDP)							
Private	5 4	6 4	1 6	3.7	1 1	3 9	3 1
Public	2.4	0 7	1.4	2 9	0 6	1 8	3
Total	7 8	7 1	3 0	6 6	1 7	5 7	6 1

* Organized in ascending order of PPP-adjusted per capita GDP in 1997

** Data from World Bank World Development Indicators, 2000/2001 and WHO Report 2000, unless otherwise noted

*** Data on poverty for Chile was obtained from USAID, 1998

3.2 Kenya[12]

(a) Context

Kenya is the poorest country of the selected case studies. Forty-two percent of its population lives below the national poverty line (World Development Indicators, 2001). In 1997, total health expenditure was 7.8 percent of GDP. Kenya relies heavily on private expenditure which represents 70 percent of total health expenditure. A severe economic crisis in the early 1990s led to a steady decrease of government allocations to health, from $29 per capita in 1990 to $17 in 1993. By 1998, total public per capita expenditure in health had returned to its pre-crisis level of $30.

(b) User-fee policy and its impact on the poor

Beginning with independence in 1963, Kenya committed itself to free public education and health care. Owing to the economic crises of the late 1980s, however, in 1989 the country introduced cost-sharing policies to raise revenues in outpatient wards in hospitals and in health centers. Over time, user fee revenues have increased substantially from Ksh. 28 million in FY 1990/91, to Ksh. 325 million in FY 1998-99 (Table 5). In FY 98/99 they accounted for 3.4 percent of non-wage recurrent health expenditures (Owino, 2000).[13]

Table 5 Kenya: Cost-sharing revenue as a percentage of Ministry of Health's recurrent expenditure

Fiscal year	Cost sharing revenue (Ksh. millions)	Cost sharing revenue ($ millions)	MOH recurrent expenditure (Ksh. millions)	MOH recurrent expenditure ($ millions)	Percentage
1990/91	28	1 1	3,040	117	0 92
1991/92	34	1.1	3,500	116	0.97
1992/93	61	1.4	4,580	102	1 33
1993/94	130	2.3	5,900	103	2 20
1994/95	238	4 4	7,420	138	3 21
1995/96	200	3.7	8,280	153	2 42
1996/97	205	3 6	8,760	152	2.34
1997/98	186	3.1	9,100	152	2.04
1998/99	325	4.7	9,620	140	3 38

Source: Owino, 1998.
Note. The figures exclude contributions by Kenyatta National Hospital

Government health facilities have established official fees that are in principle uniform across the country and set nationally by the Ministry of Health (MOH). In practice, however, responding to declining government budget allocations and inflation, several District Health Management Boards have increased their fees without prior consultation with or approval from the MOH, resulting in wide divergence between official and actual fees (**Error! Reference source not found.**, from Owino 1999).

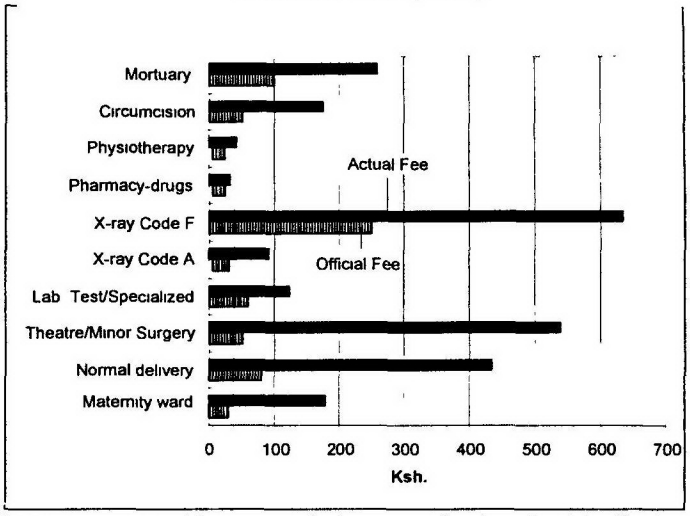
There is evidence that cost recovery may be adversely affecting access by the poor and that in some cases it may have had a negative impact on efficiency of health service provision. A study by Moses (1992) covering a nine-month period shows that the introduction of fees for patients attending Nairobi's Special Treatment Clinic for sexually transmitted diseases (STDs) resulted in a 40 percent drop in attendance by men and a 65 percent drop by women. Another study by Osuga and Nordberg (1993) examines the

[12] Information for this case study is drawn mainly from Owino, 1998, 1999, and 2000, IPAR policy brief, 1999 and Newbrander 1995

[13] . When Kenyatta Hospital is included this percentage rises to 14 5 percent for FY 94/95

"before after" effects of the introduction of fees at a rural hospital, two health centers and two dispensaries in Kibwezi Division in Machakos District in Kenya. Relative to previous years when services were free, outpatient attendance dropped significantly (ranging from 28 percent to 50 percent) in the first six months at all fee charging facilities. Admissions for inpatient care increased at the hospital but length of stay fell, while in health centers admissions, length of stay, and deliveries declined. Attendance at those services that continued to be free remained stable or increased slightly at the hospital, but at health centers trends were mixed, with declining use of under-fives care and ante-natal care and increased use of family planning services. The drop in attendance was followed by a recovery, but levels remained 20 percent to 40 percent below pre-fee levels. Similarly, Mwabu and Wang'ombe (1995) show that the introduction of outpatient fees in Kenya's public hospitals brought about a substantial drop in demand. Finally according to a 1995 analysis of household interview data by Newbrander and colleagues (2000), 91 percent of poor households reported that they knew of someone who recently had not sought care because of inability to pay. Sixty percent of respondents reported that finances were a major factor behind the drop in demand in government facilities; 30 percent cited dissatisfaction with the service provider or service quality as a reason for seeking alternative treatments.

Figure 10 Kenya: Official and actual fees in MOH facilities, 1994 (KSH)



(c) Protection mechanisms

In an effort to mitigate the negative effects of user fees on access by the poor, MOH central level staff introduced a system of exemptions for certain categories of persons or patients afflicted with certain illnesses. Since 1992 exemption categories have been reduced (Table 6). For example, whereas before 1995 children under 5 years were waived from fees in all primary care facilities, after 1998 only about one-half of all facilities kept this waiver.

Facility staff (medical superintendents, matrons, hospital secretaries, or administrative officers) determines waivers locally and grant them to the poor on the basis of income and health status. Initially, local leaders and their assistants were in charge of screening and recommending patients for waivers. This process was deemed prone to political interference and led to delays in treatment (Owino, 1999). Also at the beginning of this policy, the MOH published rules for establishing eligibility on the basis of income, but the rules proved difficult to interpret and implement. Measuring individual and family cash income constituted a major hurdle leading health staff to use income proxies for waiver eligibility. A study of 9 facilities shows that in practice a wide variety of proxies are used. Also, facilities seem to combine different patient attributes to determine poverty (for example clothing, mode of transport to hospital and number of relatives accompanying the patient, Table 7).[14] Some criteria –such as occupation, clothing, and hairstyles– seem common to all facilities, whereas others –number of dependents to family size, relationship with accompanying family members– are used only by a few entities.

Table 6 Kenya: Categories of patients and illnesses exempted, 1989-98

1989/90	1992	1994	1998
Children	0-15 yrs	0-5 yrs	0-5 yrs*
Prisoners	Yes	Yes	Yes
Tuberculosis (TB) patients	Yes	Yes	Yes
Leprosy patients	Yes	Yes	Yes
Patients from charitable/destitute homes	Yes	Yes	Yes
Family Planning	Yes	Yes	-
STD/AIDS	Yes	Yes	-
Internal MOH referrals	Yes	Yes	-
Unemployed (certified by their) District Officer	Yes	Yes	-
Antenatal and postnatal clinics	Yes	Yes	-
Civil servants	Yes	-	-
Unmarried children under age 22 (except for inpatient charges)	Yes	-	-

Source: Owino, 1999
Notes
"Yes" if category included in the exemption list sometime during corresponding period
*Children under 5 exempted in 50 percent of facilities visited, though benefits were restricted to consultations. Plans reportedly underway to remove this group from exemption list (Owino, 1999)

The staff issuing waivers is required to fill out a standard MOH waiver form and forward it to the medical superintendent or his or her delegate for approval. The administrative process involved in granting waivers is cumbersome, on average lasting about 1-2 hours. When the local administration is involved, the approval process sometimes may take up to a a full day. Often the process is hampered by the lack of adequate stationery and qualified staff. Nurses, clinical and medical workers, and other professional staff are usually in charge of granting waivers, an activity that interferes and competes with their regular health care duties. The process of assessing and exempting patients is thereby often delayed or postponed. No explicit policy is in place to compensate facilities for revenue foregone due to waivers and exemptions, and thus more waivers and exemptions mean less revenue for the facilities.

Table 7 Kenya: Eligibility criteria for waivers in selected MOH health care facilities

	Facility								
Attributes relating to the patient	1	2	3	4	5	6	7	8	9
Occupation	X	X	X	X	X	X	X	X	X
Mode of dressing/hairstyles	X	X		X	X	X	X	X	X
Mode of transport to hospital				X	X	X			
Recommendation by local administration		X		X	X		X		X
Direct observation			X		X	X	X	X	X
Number of dependents/family size		X		X					
Nature and type of relatives		X	X						
Number and type of accompanying family members	X		X	X	X		X	X	
Length of stay after discharge*			X		X	X	X		
Recommendation by social worker		X				X		X	

Source: Owino, 1998
Notes:
"X" means attribute used at facility for eligibility assessment (Owino, 1999)
* When patients did not pay the bill they were not allowed to leave the health facility

[14]

(d) Results

There is no systematic government monitoring or evaluation of the performance of protection mechanisms, and therefore there is a lack of data on coverage of the target group. A recent survey of 17 facilities reported by Owino (1999) shows that waivers rarely exceeded 2 persons per month –an insignificant figure given that 42 percent of Kenyans live below the poverty line. Beneficiaries of exemptions and waivers are mainly inpatients and outpatients with simple medical conditions and seldom include patients with costly treatments. This finding may reflect the reluctance of providers to forego significant revenue though costly exemptions. It also indicates a situation where exemptions are absent where they are most needed: costly treatments have the most detrimental impact on the poor. The low level of exemptions contrasts with the high prevalence of poverty; it reveals the existence of serious problems of under-coverage, and thus points to major deficiencies with this protection mechanism.

In a survey conducted by Owino (1998) 80 percent of inpatients and 86 percent of outpatients were not aware of waivers and exemptions. Even those who did know about them were unclear about eligibility criteria. Staff attitude towards waivers and exemptions was usually negative and they have been reluctant to publicize protection mechanisms. Fearing revenue losses, staff felt that information on waivers should not be easily accessible to patients and that patient relatives should assume the burden of fees. In fact, according to Owino, there seems to be a general reluctance by facilities to create awareness about the waiver system. In the same study, about 70 percent of the facility clerks interviewed were against publicizing the system.

There have also been reports of leakage, especially in the form of exemptions for civil servants and health personnel (Owino, 1999). According to a study by Newbrander (1995), only one-third of all waivers and exemptions were accounted for by the poor, and a full two-thirds accrued to the non-poor. Leakage from waivers through individual targeting did not seem to be a problem. Based on a one-day exit interview, Newbrander reports that 100 percent of waivers granted through individual targeting were given to the poor. Still, there seems to be other evidence of corrupt practices in the granting of waivers and exemptions Owino (1999) reports that nurses in charge of wards were known to seek bribes in exchange for helping patients abscond without paying or for getting preferential treatment in the fee-determination process. It seems also to be common practice that health staff benefits from waivers and exemptions alleging that their salaries are too low.

(e) Lessons learned

User fees resulted in a sizable drop in demand in hospitals, and the poor reported access problems related to the imposition of user fees. Measures to preserve access by the poor through waivers and exemptions are characterized by under-coverage and leakage. Factors responsible for this poor performance include the following:

- Lack of clear guidelines to determine eligibility.
- Absence of staff incentives to grant and promote exemptions and waivers, including the lack of mechanisms for compensating health facilities for revenue foregone.
- The protection system has not accounted for administrative costs involved in granting waivers. The approval and granting of waivers and exemptions is hampered by the lack of adequate stationery and qualified administrative staff –medical social workers. This lack of specialized staff has required that waiver functions be undertaken by nurses, clinical and medical officers, thus interfering with their medical duties and hampering the effectiveness of the waiver procedure.

- Lack of information and misinformation among potential beneficiaries about protection mechanisms.
- Perceived low quality of services by all prospective patients, including the poor.
- Ability of health workers and other non-target groups to capture subsidies through waivers and exemptions.

3.3 Cambodia

(a) Background

Cambodia is emerging from decades of civil war and unrest. It is estimated that between one-fourth and one-third of Cambodia's population died during the war, from violence and starvation. Since the early 1990s Cambodia has begun to rebuild its economy, achieving significant economic growth rates, and the government has pledged to improve the provision of social services. Still, Cambodia remains a very poor nation with a national prevalence of poverty of 36 percent and with a high concentration of poverty in rural areas. Meager public budgets for health have done little to reduce reliance of user fees in the public system and to alleviate the burden that fees represent for the poor.

(b) User fee policy

Cambodia's health sector relies heavily for its financing on private payments for health care. Knowles (2001) states that

> Overall health sector funding in Cambodia absorbed 12-13 percent of GDP in 1996-97, by far the highest share among Asian developing countries. Another striking feature of the financing of Cambodia's health sector is the large role played by out-of-pocket household expenditures, which accounted for 82-84 percent of total sector financing during the same period. In contrast, the government plays a relatively minor role in sector financing, accounting for only about 4-5 percent of the total. Official donor assistance (ODA) and direct funding by NGOs also contribute significantly to sector financing, accounting for about 8-12 and 2-3 percent respectively of total sector financing during this period.

According to the 1996 Health Care Demand Study, on average health care accounted for 22 percent of all estimated household expenditures. This percentage increased with income, except for the poorest families that devoted 28 percent of their total spending to health care. In 1996 the monthly mean expenditure on health care per household was estimated at $13.90 (MOH / WHO / GTZ, 1998:20); adjusted by internal inflation this was equivalent to $27.10 per person per year in 1999.[15]

The World Bank (2001) carried out an analysis of affordability of government-provided health services, by expressing health care spending in relation to household non-food expenditure per capita (a proxy for discretionary household income). They concluded that health care was extremely expensive for the poor. One outpatient visit to an ambulatory government facility cost $30.00, or the equivalent of one-third of a year's non-food spending for those in the poorest expenditure quintile; one hospital admission cost on average $87.00, or more than twice the average annual nonfood spending.

In 1996 the MOH introduced the National Charter on Health Financing (NCHF). This initiative sought to formalize cost recovery in the form of user fees around the country. The NCHF also made possible the

[15]. The Cambodia Socioeconomic Survey of 1997 found that health expenditure per household was US$18 60 per month, equivalent to a per capita out-of-pocket expenditure per year of US$42

development of health financing pilots (with user fees or other financing mechanisms) in public facilities, with the explicit purpose of "increasing financial resources to the sector and obtaining better value for money" (National Charter on Health Financing in the Kingdom of Cambodia, 1996:2). Three specific goals were implicit in this statement: to reduce unofficial charges and household out-of-pocket expenditures; to improve quality of care through increased and timely availability of medical supplies; and to motivate staff through performance-related payments funded by fees. In accordance with the third goal, the government defined a revenue allocation rule whereby 49 percent of user-fee revenue could be used to improve salaries, 50 percent could be devoted to pay for the facility's non-salary operating costs, and a nominal 1 percent must be transferred to the National Treasury. Under the HCFC, therefore, facilities retain and control locally 99 percent of all user fee revenue.

(c) Protection mechanisms

Exemptions from payment in health facilities are not common in Cambodia, although most public facilities do provide them according to some ad-hoc procedures. The World Bank (1999) reported that in 1997 only about 18 percent of users of health care services were exempted from fees around the country, and noted that individuals from higher income households were more likely to get exempted from user fees than the poor.

A major obstacle to acceptable levels of exemptions, i.e., ones consistent with Cambodia's high levels of poverty, is the conflict that exists between health staff income and their awarding of exemption to patients. The average staff of a government health facility earns a monthly salary of between $10 and $15. This income level is below the poverty line. To subsist, government health workers depend heavily on revenue from user fees and from other remunerated activities. In interviews with facility health staff in three provinces (Takeo, Sotnikum, Kandal) and the capital city of Phnom Penh, Bitran (2002) found that owing to cost recovery from user fees, the average monthly income of a government health worker may be as much as $180, of which less than 10 percent comes from its official salary, and the rest from user fees. Wilkinson *et al.* (2001) note the following:

> There is an inherent tension in a facility seeking to operate a viable exemption scheme and a viable salary incentive scheme. The two systems are essentially in competition, especially in facilities which are operating at, or near to full capacity. In this situation, every exemption provided is effectively paid for by the staff themselves from their salary uplift. If, as in Takeo, the hospital is operating at full capacity, and is striving towards improving efficiency, then granting exemptions would be virtually intolerable Ironically, exemptions are more likely to be granted in facilities which are performing less well, and where serving a patient for free does not necessarily mean excluding a fee-paying patient. The competition, outlined above, between patients for more exemptions and staff for greater salary incentives is actually part of a broader systemic tension, inherent in the design of the health financing scheme, between equity and efficiency. There is a real danger that increasing equity, by lowering prices and providing more exemptions to the poor, will undermine efficiency, both at facility level and [Operation District] O.D. level. Conversely, as facilities strive towards greater efficiency, there is a real danger that the poor will become even more marginalized. If the tensions outlined above are to be relieved, it is clear that the mechanism for financing exemptions must be completely separated from the mechanism for financing salary supplements and operating costs.

Exemption policies vary widely among provinces and districts in Cambodia (Espinosa and Bitran 2000). For example in 1999 one-fourth of the population under the responsibility of Rovieng health center was waived from fees. By contrast, at Pereang operational district the rule is that no waiver is granted, except in very special cases. The policy, there, is to keep fees low enough to make everybody pay while at the same time avoiding problems of financial accessibility for the poor. In Takeo Hospital, the rate of waivers was estimated as 2 percent while at Pursat Hospital the value of waivers accounted for 13 to 15 percent of cost recovery revenue (Pursat Report on user fee payments, January 2000).

Aside from the system of informal waivers already discussed, two interesting formal models exist in Cambodia for promoting equitable access to health services by the poor: the Calmette Hospital model and

the equity fund (EF) model. Calmette Hospital, also known as the National Hospital, is a semi-autonomous, 250-bed public facility located in Phnom Penh that provides health services free of charge to the poor and that gets reimbursed for it by the government on the basis of a fixed payment of $26.00 per hospitalization. A special mechanism known as Chapter 31 (a budget line item reserved for social allowances for health staff), operating exclusively in Calmette, makes this protection system possible. Calmette has a formal fee schedule for non-poor patients and a formal means testing mechanism for classifying patients into the paying and exempt categories on arrival. Calmette devotes about one-third of its beds to indigent care. Occupancy rates are 65 percent for paying beds and 100 percent for the beds devoted to the poor. Calmette Hospital also receives financial and technical support from the French Cooperation, an agency that is currently seeking government approval for expanding the Calmette model to six other hospitals, of which two are in Phnom Penh and four in the provinces. Unfortunately, tight public budgets make this prospect unlikely and government officials seem unwilling to generalize or expand this system.

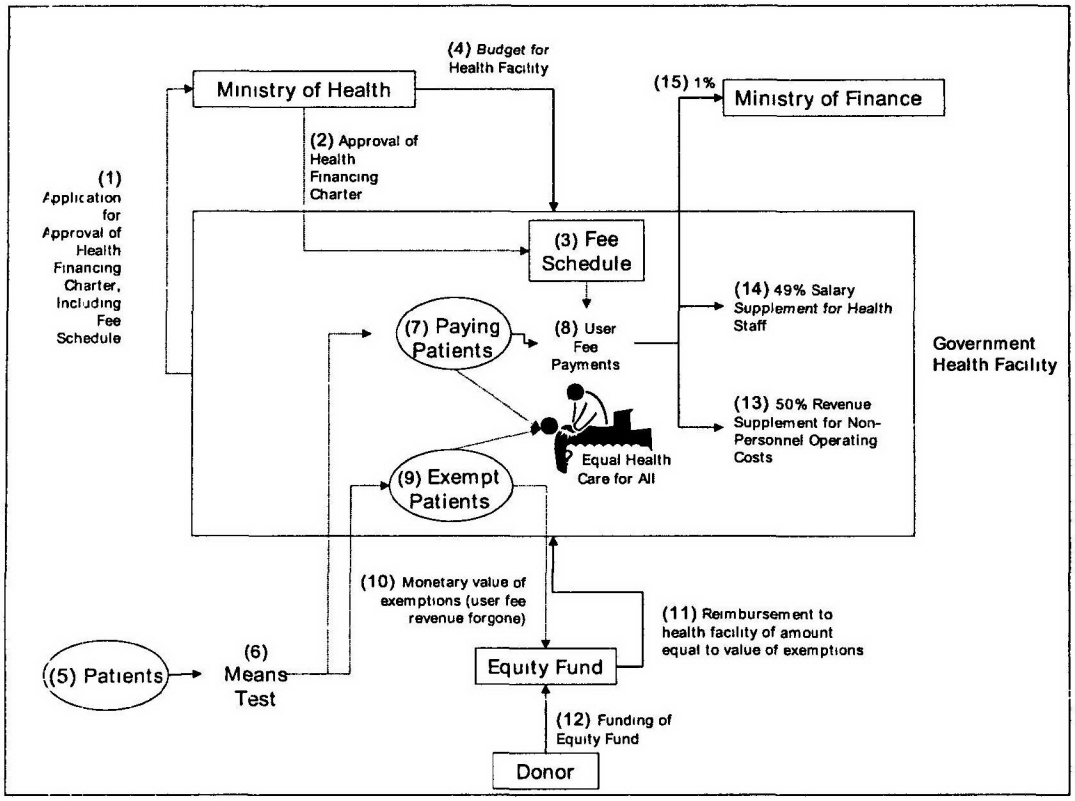
Equity funds were conceived in Cambodia to finance the cost of health services provided at no charge or at reduced prices to the poor. Unlike the Calmette model, which so far remains a single exception, the EFs model is likely to become more widespread. An upcoming World Bank loan may promote and finance EF expansion. The basic mode of operation of an EF is illustrated in Figure 11. The process of setting up an EF begins with the submission by the health facility to the MOH of an application for approval of its health financing charter, including its fee schedule (Action 1). Once the charter is approved by the MOH (Action 2), the facility officially adopts its fee schedule (Action 3), including some criteria to waive the poor. The MOH, in turn, quantifies the budget for the health facility, in principle taking into account the provider's expected ability to generate complementary revenue from users (Action 4). Patients arriving in the facility (Action 5) and wishing to be waived from fees are subject to a means test to determine their eligibility (Action 6). Patients applying but found not eligible for waivers, along with patients not applying for waivers (Action 7), are subject to and must pay the provider's customary fees (Action 8). Exempt patients, instead, are offered care for free or at a reduced price (Action 9).

Periodically the health facility reports to the EF on the level of waivers provided as well as on the monetary value equivalent of the subsidized services (Action 10). For example, the provider may keep a record of all services delivered for free and then, based on the user fee revenue foregone, at established prices, it bills the EF. The latter in turn reimburses the provider, after controlling and approving the statement submitted by the provider (Action 11). The EF requires a periodic refill of its fund (Action 12), which gets depleted with the reimbursements to the provider. EF financing has been, until now, the role of donors (e.g., the Swiss Red Cross in Takeo Hospital, the U.K. and Save the Children in Sotnikum, and the U.K. in the Phnom Penh Urban Health Project), but there is nothing in the design that would preclude the government from financing EFs.

Not all EFs operate in exactly the same way; there are variations which may have important behavioral implications and consequences on the performance of the health system. They include the management of the waiver process; where lies the responsibility to establish eligibility; the method used to pay the provider; the insertion of EF in referral system; and the type and extent of financial protection.

Waivers may be managed either by health staff, as in Takeo Hospital, or by the combined and coordinated work of health staff and EF clerks, as in Sotnikum and the Phnom Penh Urban Health Project (PPHUP). In Sotnikum, for example, health staff in the referral hospital first detects signs of indigence among patients, and then refer these patients to the EF for a means test. Likewise, the responsibility to determine eligibility may be in the hands of EF clerks, health staff, or both. In Sotnikum the ultimate decision about the granting of waivers rests with a specially trained professional who carries out a formal means test of applicants. Also in Sotnikum EF staff visit patients in their homes after discharge, to confirm the information provided during the means test.

Figure 11 Cambodia: Operation of equity funds



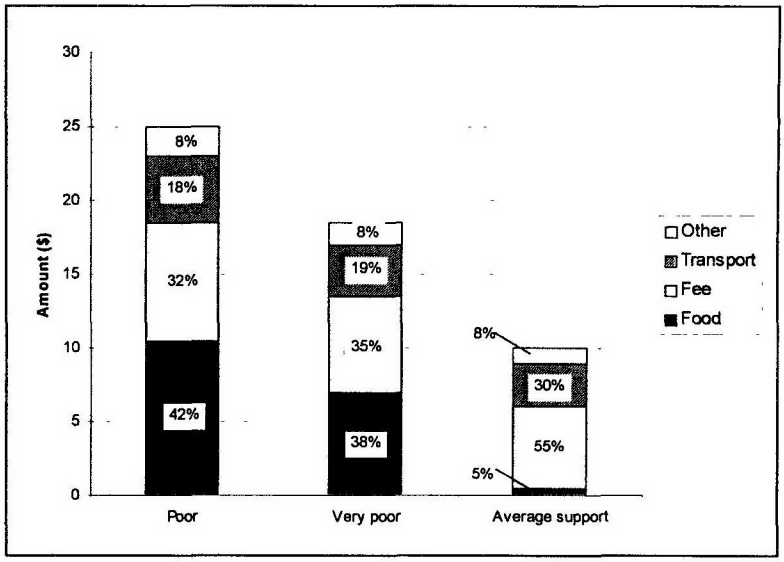
Source Bitran 2002.

Providers may be given a fixed budget to finance waivers, as in Takeo or in the PPUHP, or they may get paid by the EF on a fee-for-service or per case basis, as in Sotnikum. The EF may promote patient flow through the referral system as in PPUHP, where patients seen in health rooms who need a referral get a waiver for the fees associated with health services required at the higher level. In Sotnikum, instead, as in Takeo, exemptions are granted when patients show up in the hospital, because the EF there does not operate at, or in coordination with the primary care facilities.

The extent of protection afforded by the EF varies as well, in terms of the types of services it covers and the proportion of the services' costs it pays for. Thus, an EF could in principle provide protection against catastrophic health problems (none does so far), or it could finance all or part of the costs of an episode of illness. All three EFs studied by Bitran (2002) provide financial protection for high-cost services in hospitals, but they have implicit or explicit limits in what they cover and therefore may not be providing true catastrophic coverage. Aside from the extent of coverage of health expenditures, EFs may or may not cover other health-related expenses, such as transportation to and from the health facility, food for the patient and family members, and the like. Hardeman (2001) examined this issue, among other aspects of EF, through a case study in Sotnikum. He examined a sample of 51 individuals who had been hospitalized in June-July 2001 to assess patient expenditures and level of patient financial support, if any, by Sotnikum's EF. He found that among the poor and the very poor, the highest expenditure associated with a hospitalization was food, on average varying in the range 38-42 percent (Figure 11). Hospitalization fees were the second most important patient expenditure, representing about 32-35 percent of all expenses. Transport costs were the third most important category and accounted for just below 20 percent. Other expenses represented 8 percent. Whereas Sotnikum's EF supported all four kinds of patient expenditure, the structure of its support did not match that of patient spending: one-half of the aid was directed toward hospitalization fees and one-third toward transport expenses. Only 5 percent of the average support to patients was devoted to food outlays. In absolute terms, the average support per patient amounted to $10.00, and covered the bulk of hospital fees and transport costs. Total

average expenditure by the poor and the very poor amounted to $25 and $18, respectively, and therefore Sotnikum's EF covered 40 percent of average spending by the poor and 56 percent of spending by the very poor.

Figure 11 Cambodia: Mean patient expenditure per hospitalization and average support by Sotnikum equity fund, 2001 ($)



(d) Results

Knowles (2001), who conducted an evaluation of the PPUHP EF, concluded that the project effectively protected the poor against the high costs of health care, and also prevented people from falling into poverty as a consequence of high health care costs. He also estimated that the EF was a fiscally efficient policy, because the costs of running the EF were smaller than those associated with poverty alleviation for those who, as a consequence of health care payments, would otherwise fall into poverty. Knowles also noted that the costs of running the EF in PPUHP were high because of the high incidence of expatriate managers costs.

Hardeman (2001), who evaluated the Sotnikum EF, provided an equally upbeat vision. He found that the EF improved equity in access to health services by not discriminating in the provision of care between the poor and the non-poor. The cost of supporting each hospitalized patient was, on average $10, making it possible for poor and near poor patients to receive medical services worth $50 ($10 co-financing by the EF; $40 financed by the government on average, through the support of recurrent hospital expenditures). He also found that there was virtually no leakage of benefits to the non-poor. He concurred with Knowles' finding about the EF's ability to prevent poverty from high health-related expenditure households vulnerable to poverty.

(e) Lessons learned

Hardeman (2001) identified a number of limitations in the Sotnikum EF model. First, he noted that the EF was passive in the sense that it did not actively search for the poor in need of assistance, but instead waited for them to show up. This likely resulted in under-coverage of the poor, a phenomenon that may be overcome gradually as the EF becomes known to the local residents. He reported that an estimated 30-40 percent of the population was poor or near-poor in Sotnikum district, but only 15-20 percent of the hospitalized patients fell in those two categories. He also concluded that there was a lack of awareness about the EF, noting that the total number of patients so far receiving EF support (309 people) was still small in relation to total beneficiary population of 220,000. He felt, however, that awareness would improve in response to current community involvement in EF promotion. He also remarked that the poor were still subject to financial uncertainty associated with health care demand, since the outcome of the means testing procedure was unknown to them prior to seeking care. He remained concerned about the EF's ability to improve accessibility and to have a noticeable impact on use by the poor. He also worried also about the replicability of the EF, particularly its management structure and its methods for identifying recipients and paying providers. A final concern was the ability of future EFs to control and maintain appropriate levels of quality of subsidized health services.

In his evaluation of the PPUHP EF, Knowles (2001) recommended that the existing caps in the size of EF support of patient expenditures be removed, that case-based be maintained as the reimbursement system for providers, that a proposal for the adoption of a flat fee reimbursement be rejected, and that the EF reimburse providers at full cost instead of the current 70 percent of cost. He also advised that the means testing procedures used in the EF to avoid type I errors (wrongly denying benefits to the truly poor) be discontinued. Other recommendations included the addition to EF benefits of vouchers for home-based obstetric care; the provision of patient partial assistance for referrals to all higher-level facilities; the continuation of provision by the EF of supplementary welfare payments to individuals to encourage the continuity of care in higher level facilities; the turning over of EF management to a local NGO; and the future opening up of the EF to the participation of the non poor in exchange for a monthly fee.

Main lessons arising from the Cambodia case follow:

- EF seem to be an effective mechanism for targeting assistance to poor individuals in need of health care in Cambodia

- Private patient costs of care other than the health professional's fees and medicines can be quite substantial; to be effective, EFs should also contemplate paying for such costs as transportation and food for patients and accompanying relatives.

- The initial operation of EF has been characterized by under-coverage. Further dissemination of e EF may lead to greater demand for their assistance.

- The provision by EF of waivers at the time of care involves uncertainty for prospective beneficiaries who do not always know their chances of getting a waiver. This may limit demand for EF assistance and for health care by the poor. The possibility of distributing waivers ex-ante at the household level should be considered by those designing EFs.

- Paying providers for the medical services delivered to EF beneficiaries seems a key factor in assuring access by the poor to timely and good quality care. Such a payment confers an economic benefit to providers which makes them indifferent between treating EF beneficiaries and regularly paying patients. Thus, they do not discriminate against patients receiving EF assistance.

3.4 Ghana[16]

(a) Background

Ghana's population of 20 million has a PPP-adjusted per capita income of $1,760. In 1999 per capita health expenditure was $54.00 (PPP-adjusted) and total health expenditure amounted to 3 percent of GDP, with 61 percent being privately financed mainly through out-of-pocket payments by households. According to the World Bank (1999), one-third of Ghana's population lives below the national poverty line. In recent years Ghana has undergone economic difficulties that have led to severe budget constrains and restricted resources for health financing. In the 1990s government health spending fell both in real

. Based on Garshong Ansah, et al., 2001; Nyonator and Kutzin 1997, Nyonator, Daimenu, Amedo, and Eleeza, 1996; and Coleman, 1997

terms and as a percentage of total public expenditure (from 11.1 percent in 1991[17] to 4.7 percent in 1998).[18]

(b) User-Fee policy

In 1985 the government formalized the policy of user fees with the release of Law 1313 on fee regulations. The law specified fees for most services and called for full cost recovery for drugs. In the following years, drug fees were adjusted annually by inflation whereas all other fees remained nominally constant and therefore became increasingly outdated. In the time that has elapsed since the inception of fees, the real value of official non-drug fees has dropped by more than 90 percent (Nyonator, 1997). Prior to 1983 any revenue generated from user fees by government health institutions went into a central government account. Since 1983 health facilities have been allowed to retain and spend locally their user fee revenue. Proceeds from fees are kept in two separate bank accounts: one pays for drugs and another pays for non-drug staff expenses. Neither account can be used to supplement staff income, an explicit policy measure seeking to devote fees to the financing of non-personnel quality improvements.

(c) Protection mechanisms

Law 1313 provided for waivers for "paupers" but failed to give an explicit definition of such a term and to include guidelines for the identification of paupers. The law also called for waivers and exemptions for health workers, for some preventive and curative services for women and children (immunizations, pre- and postnatal care), and for patients with tuberculosis, leprosy, and mental disorders. In addition, the law contemplated partial exemptions for patients suffering from a wide range of communicable diseases. Since the publication of Law 1313 the target groups and qualifications for exemptions have been broadened by policymakers in response to emerging health issues and policy priorities. Groups added to the list of the waived are children under five and people over the age of 70, while conditions added to the exemptions list are snakebite, rabies, and buruli ulcer (Grashong et al., 2001). The law thus considered a mix of targeting mechanisms including targeting by type of service, group targeting, and individual targeting (the "pauper"). Individual assessment of ability to pay is to be undertaken by the social welfare officer at the hospital who is expected to carry out a means test upon admission. Facilities are reimbursed for waivers and exemptions. The national level transfers funds to the regional level from where they are allocated to districts, and from there to health facilities.

(d) Results

The combined effect of a drop in government funding and a real reduction of fees due to inflation led public health providers to adopt their own user fee policy as in Kenya (see above). In a sample of four government district hospitals (Table 8), actual fees were systematically higher than official fees and large variations in fee levels were observed across facilities.[19]

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17 Nyonator, 1997.

18 World Bank, 1999.

19 Adapted from Coleman, 1997.

In addition, unofficial, or "under the table" payments became a common practice to cover resource shortages. A study undertaken in Ghana's Volta Region found that the median user payment in government hospitals was 8 times higher than the officially authorized fees. Although actual fees seem well above the official amounts, they are below official fees if these were adjusted by inflation. Multiple fees were charged for different services during a single patient visit, leading to administrative workload, especially for nurses. In hospitals, deposits were asked of patients prior to admission. Data from 15 facilities located in the Volta Region showed that user-fee revenue accounted for about two-thirds of non-salary revenue in public health centers and for more than 80 percent of non-salary revenue in public hospitals. According to more recent information, user fees constitute a substantial part of revenues for many hospitals and, by 1999, represented about 12 percent of total funding for public hospitals, up from 8 percent two years earlier (Table 9).[20] These figures illustrate the current high dependence of government health facilities on user-fee revenue to finance non-salary costs.

Table 8 Ghana: Official and actual fees charged in government district hospitals, 1997 (cedis)

Price category	Official fee	Actual fee (mean)	Actual fee over official fee	Maximum actual fee over minimum actual fee
Outpatient department	50	350	7 0	2 5
Hospitalizations	100	325	3 3	2 5
Deliveries	100	2,000	20.0	3 0
X-Rays	200	2,000	10 0	1.0
Hemoglobin	10	475	47.5	1 3
Urine tests	40	575	14.4	1 6
Stool tests	20	475	23.8	1 3
Cesarean	1,000	55,000	55 0	20 0
Appendectomy	1,000	55,000	55 0	22 0
Hernia removal	500	28,333	56.7	10 0

Source Adapted from Coleman (1997)

(e) Protection mechanisms

Even though no systematic monitoring systems exist, studies indicate that exemptions were seldom awarded. According to MOH data (Nyanator *et al.*, 1996), only the blind or the mentally handicapped were deemed poor and were therefore exempted. Patient exemptions on the grounds of inability to pay were uncommon. A survey of the Volta Region revealed that 5 out of 24 health facilities provided no exemptions whatsoever. The total number of waivers and exemptions represented less than 1 percent of the total number of recorded patient contacts, and the most common reason for exemptions (71 percent of the total) was that the patient was a health worker. Patient exit interviews confirmed the low coverage of protection mechanisms: of 313 patients selected at random, fewer than 2 percent were fully exempted from payment. A more recent survey of selected areas in Ghana confirms this finding: "Household heads were asked whether they or any member had ever been treated free at any government health facility. In the 200 households studied in AMA (name of the region), only six (3 percent) had someone treated free (i.e., waived or exempted). In the rural sample, only three (less than 2 percent) had ever received free

Table 9 Ghana: Revenue by funding source (in million cedis)

Source of Funding	1997	1998	1999	Distribution 1997 (percent)	Distribution 1999 (percent)
MOH	139.5	195 0	238 2	43	57
User fees	27.7	33 0	50.7	8	12
Health fund	6 4	12 6	32.9	2	8
Earmarked	6 8	7 8	13 9	2	3
Donor managed	43 5	34 9	43 1	13	10
Donor total	56 6	55 2	104 9	17	25
Credits	101 6	77 0	27 8	31	7
Net total	325 4	360 2	421 6	100	100

Source: Adapted from Coleman (1997).

[20] Reference provided by F Decaillet, World Bank

treatment. In the former case, 24 households have someone who had been treated free but for whom someone had paid (their own or their spouse's employer or)"(Saprin, 2001).

Recent reviews by Garshong (2001) and Coleman (1997) show that health facilities are generally reluctant to waiver or exempt patients and charge fees for services that are officially and universally free of charge (Table 10 and Table 11[21]). This once more illustrates the widespread disregard that exists among public facility managers for national policies on fees and exemptions.

Table 10 Ghana: Percentage of patients paying full user fee by patient category and by region

	Patient category						
Region	Paupers (N=20)	Pregnant women (percent) (N=149)	Child Welfare Clinic (N=35)	Curative care children under five (percent) (N=129)	Care for those aged 70 and over (N=103)	Tuberculosis (N=39)	Other specific diseases (N=28)
Ashanti	-	100	100	100	60	67	100
Brong	-	50	38	100	63	0	40
Central	-	50	100	75	13	33	-
Eastern	0	82	100	50	73	0	100
Greater Accra	25	93	100	94	63	43	100
Northern	33	18	0	24	8	-	43
Upper East	50	24	0	56	44	0	0
Upper West	50	42	0	31	9	33	20
Volta	0	56	-	100	31	0 / 6	50
Western	100	40	60	100	50	33	-
Total	40	56	51	71	41	28	36

Source: Garshong *et al.*, 2001

Seven factors seem to explain low coverage of protection mechanisms in Ghana. First, exemption categories were not well defined by health authorities or well understood by health personnel and various local interpretations of the law existed. Below is a list of common definitions of the term "pauper" according to a recent survey by Garshong (2001):

Table 11 Ghana: Proportion of facilities charging for exempted services

Disease officially exempted	District Hospitals
Measles	10/11
Typhoid	11/11
Hepatitis	11/11
Tetanus	11/11
Sickle cell	11/11

Source. Garshong *et al*, 2001

- Someone who has no relatives
- Someone who has no means of looking after him/herself
- A disabled person with no money and no family
- Someone who cannot pay, who is poorly dressed, and who has a chronic illness
- Someone who has no traceable relatives and is financially not capable of paying for services received
- Someone who is classified by the priest or by management as unable to pay the required amount

Second, many potential beneficiaries were unaware or misinformed about waivers and exemptions and even facility staff did not have a full understanding of the policy. The following statement collected by

[21]. Coleman, 1997.

Nyanator and his colleagues during focus group discussions gives a sense of the high degree of public's misinformation.

> "To be fair and frank, I am not aware of any such facility [that grants waivers and exemptions for the poor]; however, I am aware that hospital bills of government workers and their dependents are refundable by the government." (Nyanator, 1997)

In a more recent study by Saprin (2001) based on a sample of 33 patients who visited a public facility for treatment, he asked whether some patients knew they were not expected to pay. Virtually all of them (94 percent) were unaware of their potential right to exemptions. Also, Garshong' *et al.*'s 2001 study alluded to above shows that whereas facility staff seem to know patient waiver categories (for example the blind, the handicapped), they do not fully understand what type of services are to be exempted (for example immunizations). Focus group discussions with pregnant women held within a facility reveal major variation in the interpretation of this policy.

Third, most facilities have not made any institutional arrangements to identify poor patients. A reason given by health staff for this was the lack of social welfare workers or of specialized staff for carrying out individual assessment.

Fourth, there was no supervision or monitoring of the process of exemptions and waivers and there were no sanctions or penalties to those who did not follow the guidelines.

Fifth, there are financial and administrative difficulties in the reimbursement process for those facilities granting waivers and exemptions. In 1999, the Government of Ghana was able to provide only about 22 percent of the amount need to reimburse public providers for free care (Coleman, 2000). Also, there are serious delays in the flow of free-care compensation funds at all levels of the system. As can be seen from Table 12, facilities may have to wait between 1 month and 1 year (on average 4 months) to get reimbursed for free care. Districts also had to wait up to year. Staff interviewed noted the following:

> "The government asked us to give exemptions and they [told us] they will refund later. We found that the money was not coming, so we stopped. [...] It affects our purchasing power: consumables and drugs get out of stock." (Garshong, 2001)

In addition, facility staff complained about increased workload and stationery costs related to exemption and waiver procedures. As one health provider put it:

> "There is extra work of recording exemptions in the lab. It is extra work so someone should be employed to be doing it. We sometimes have to stay longer to work on the recording at the lab, no one pays us for it and I haven't told anyone to pay for that." (Garshong et al , 2001)

Sixth, this situation, together with the increasing reliance of facilities on user fees for their financing seems to have created strong incentives to emphasize revenue collection rather than the protection of the poor.

Seventh and finally, there seem to be problems of leakage. For instance, since the late 1980s facilities have been exempting not only health facility staff but other, non-target people have been getting waivers or reimbursements for their health care payments, including civil servants, employees of para-statal firms, members of public boards, and the staff of large corporations (Saprin, 2001).

Table 12 Ghana: Average duration of fund transfer at various levels, Jan-Dec. 1999 (months)

	Region	Districts	Institutions
Ashanti	5	4	3
Greater Accra	12	12,75	4,5
Eastern	10	4	4
Western	6	7	6
Brong	1	3	4
Volta	NA	4	5
Central	NA	NA	2,4
Upper East	3	2	3
Upper West	NA	NA	3,1
Northern	1	2	4

Source: Garshong *et al.*, 2001

(f) Lessons learned

Coverage of the mechanism to protect the poor under cost recovery remains low in Ghana. The following are the main factors explaining this situation, many of which are relevant to policy makers wishing to implement or strengthen mechanisms to protect the poor under user fees:

- Insufficient funding for the reimbursement of providers granting waivers and exemptions.
- Inconsistency of objectives at the facility level arising from a tradeoff between the objective of protecting the poor through exemptions and waivers and generating user fee revenue to pay for local costs of health services.
- Excessive bureaucracy and untimely reimbursement of providers.
- Inadequate explanation of the poor-protection policy by the central to local level implementers and lack of staff training on waiver and exemption procedures.
- Negative attitude of staff towards policies for protecting the poor as waivers mean less income and more work.
- Lack of knowledge about exemptions and waivers among potential beneficiaries in the population.
- Erosion of user fees by inflation and associated spontaneous and unregulated attempts by providers to update fees.
- High and uncompensated administrative costs for facility staff engaged in leading.

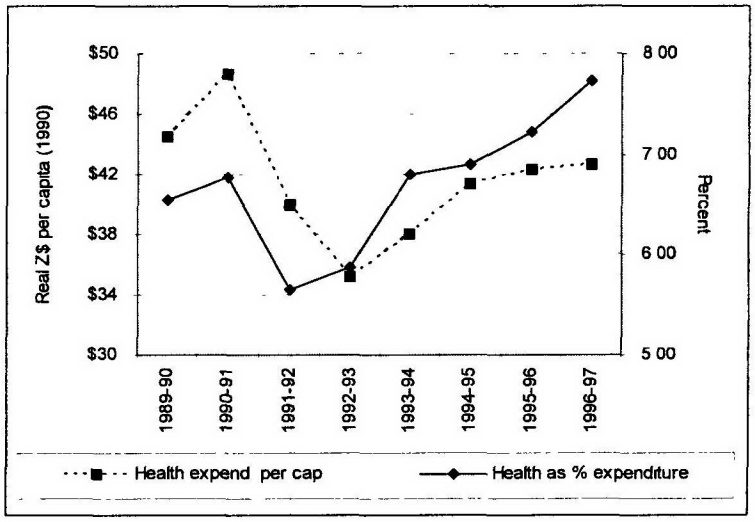
3.5 Zimbabwe[22]

(a) Background

Although Zimbabwe is not the poorest of the countries in the case study sample, it is the one with the lowest life expectancy at birth (LEB). Zimbabwe's population of 11.4 million has a LEB of only 40.41 years. In 1997 per capita income was $2.680 (PPP-adjusted) and per capita health expenditure was $49.00, representing 6.6 percent of GDP. According to the World Development Report (2000), about one-fourth of the population lives below the national poverty line. One person out of three living in rural areas stands below the poverty line and one-third of all children exhibit second and third degree malnutrition. Moreover, currently Zimbabwe is among the world's hardest hit countries with the AIDS epidemic, leading to a surge in demand for AIDS- related treatment.

Real government spending for health increased rapidly in the economic boom years following independence, and then grew only 4 percent annually from 1982 to 1988. In 1990/91, health spending peaked at 6 8 percent of the national budget. On a per capita basis, real health spending reached Z$49 (about US$20) in 1991, among the highest in Africa (**Error! Reference source not found.**). In 1991, the government launched its economic structural adjustment program just before the worst drought of the century struck. The combination of drought and inadequate implementation of the adjustment program contributed to a 30 percent decline in per capita health spending from 1990/91 to 1992/93.[23]

Figure 11 Zimbabwe: Trends in government health



(b) User-fee policy

At independence, government eliminated user fees for all those earning less than Z$150 per month. Fees were reintroduced in 1985 but inflation and weak enforcement eroded the real value of fees. In early 1994 fees were increased by an average of 2.5 times in nominal terms, with the largest increases at tertiary level care facilities and in urban areas (World Bank, 1998a). At the primary level they increased from Z$1 per visit to Z$6.5. Previously free prenatal care was set at $Z10. District hospital fees rose to Z$17 and, to streamline the referral system, a bypass fee of Z$24 was established for all those patients demanding care directly in district hospitals, and Z$38 for those doing so in provincial hospitals (Watkins, 1997). However, since accumulated inflation was more than 800 percent in the same time span, real fees were lower in 1994 than they had been in the eighties. Bank policy advice influenced the government's decision to strengthen enforcement and increase levels of fees for government health facilities (see Box 8). The actual design of the fee structure, however, was in many respects contrary to what the World

[22] The Zimbabwe case covers facts taking place in the 1990s, as the authors were unable to obtain current information on the subject

[23] This section is taken from World Bank, 1998a

Bank had suggested. For example, the Bank had recommended providing certain preventive services for free or at highly subsidized rates, an advice that was not followed by policymakers. Also, the government did not implement other recommendations made by the Bank to increase revenue. A World Bank report (World Bank, 1998a) gives the following explanation: "although user fees were not a major potential source of revenue, they were within the direct control of the MOH and could be increased by administrative decree. The other recommendations (see Box 8) were longer-term endeavors, requiring new legislation, institutional change, and the cooperation of other ministries and stakeholders".

In 1995 the government ordered the abolishment of user fees in rural health centers following an MOH study (MOH, 1995 quoted in World Bank, 1998a) concluding that the high levels of fees and widespread confusion about fees and referral policies reduced attendance without improving referral efficiency.

Box 8 Health Financing Sector Review Recommendations

The 1990 health financing study was the Bank's most comprehensive and influential analysis of health funding and expenditure in Zimbabwe. The study was organized around three major topics: resource mobilization for health; increasing the allocative and technical efficiency of health care; and developing systems and skills to support stronger health financing.

To improve **resource mobilization** for health, the health financing study recommended increasing user fees in public facilities (to restore them to real 1985 levels); establishing a national health development fund (financed through alcohol or tobacco taxes); increased "cost-sharing" by local government and church mission health providers; and expansion of the private health insurance system. The Bank suggested that the recommended measures could generate up to Z$250 million additional resources annually for the health sector (Table 12).

Of this total, the study estimated that Z$130 million could be available to the MOH (equal to more than half of the MOH's 1987–88 budget). Based on these recommendations, the ESAP and the second Family Health Project set a goal of recovering 10 percent of the MOH budget by 1995.

The improve efficiency, the Bank also recommended a reallocation of health expenditure to give greater emphasis to primary health care, improved management practices, and contracting out of services with the private sector.

Table 13 Zimbabwe: Expected increase in MOH resources, 1990 (Z$ millions)

Revenue item	Annual Revenue
User charges	42-52
Full-cost pricing for private patients	*(15-20)*
Out-patient fees	*(10)*
Drug charges	*(10-15)*
Adjusting fees for inflation	*(7)*
National Health Development Fund	80
Cost-sharing with local government and mission facilities	10-15
Expanded private insurance	80-100
TOTAL	212-247

Source World Bank, 1998a

The Bank's recommendations, however, were centered on cost recovery. The study appropriately emphasized that improved billing at central hospitals and reduced public subsidies to private care were priority actions relative to the increase in cost recovery at primary and secondary health facilities. Fees should be set to encourage clients to seek care at the lowest level of the system. At lower levels, the main goal of cost recovery was to enhance the efficiency of the referral system and deter unnecessary use. The study called for charging separately for inpatient and outpatient drugs to recover costs and deter unnecessary use. The Bank also recommended shifting the burden of proof of income to the client and increasing the income threshold for free care.

The Ministry of Finance did not allow facilities to retain revenue from user fees until late 1997. Prior to then, when user fees were retained by the central treasury, there was little incentive for facilities to collect fees. By 1995 revenue collected from user fees represented about 5 percent of total revenue in government health facilities.

(c) Protection mechanisms

In 1991 the government introduced the Social Development Fund (SDF) with two components, of which one sought to grant assistance to poor households to cover school and health care fees. Waivers were to apply to those with monthly family income below Z$150. This threshold was maintained until 1991 when it was increased to Z$400 per family. As can be seen from Table 14 steady inflation during this period eroded the income criteria. Potential beneficiaries' real income had to drop progressively to remain eligible for waivers.[24] Even when the income criterion was adjusted by inflation it was still below the threshold initially established in 1981. Also, the income cutoff point was permanently below the urban poverty line (Table 15). In addition, the income criterion did not take into account family size.

Table 14 Zimbabwe: Eligibility criteria for waivers in real and nominal terms

Year	Nominal terms	Real terms (1980=100)
1981	150	131
1982	150	111
1983	150	95
1984	150	84
1985	150	77
1986	150	67
1987	150	61
1988	150	57
1989	150	51
1990	150	45
1991	400	110

Source

To establish eligibility, potential beneficiaries had to go to social welfare offices with extensive and often hard-to-get documentation. In urban areas eligibility documents included pay slips, income-tax returns and letters from social welfare offices. This information was the basis for income determination. In rural areas this information had to be supplemented by information on household size, landholding, and type of dwelling. Unfortunately the criteria adopted proved rigid and hard to apply because only 20 percent of the population works in the formal sector and most applicants have in-kind or erratic incomes (Loewenson ,2000; World Bank, 1998a). There was some additional screening process as eligibility had to be confirmed by head teachers and village elders and potential beneficiaries had to pay administrative fees for this. High transport costs were involved and often several trips were necessary to complete this process. Eligible beneficiaries were given "free care letters" which they were to present at facilities to receive free care.[25]

Facilities were to be compensated for exemptions through the SDF in Harare. However, reimbursement to health units would take up to 8 months since they required authorization from Harare. Funding was inadequate as SDF made smaller allowances than actually required. Finally, potential beneficiaries were misinformed or uninformed about the waiver system.

Table 15 Zimbabwe: Comparison of poverty lines and eligibility criteria

Year	Income cut off point for waiver eligibility	Poverty line (month, per household)* Urban	Rural
1990	150	302	193
1992	450	529	338

Source·

* Poverty line established in World Bank 1995 poverty assessment report Level is based on resources required to cover expenses from the consumption of a minimum package of goods (for further details see World Bank, 1995).

[24]. Data on inflation was taken from information of the Central Statistical Office of Zimbabwe.

[25] Data on poverty line for 1990 is taken from World Bank, 1995. Poverty data for 1992 are expressed in real 1990 Zimbabwe dollars

(d) Results

There is substantial evidence suggesting that user fees have negatively affected the poor.[26] For example, according to the 1994 Zimbabwe Demographic and Health Survey, 42 percent of the urban poor who reported an illness in the previous month gave "cannot afford" as the reason for not seeking treatment, compared to 14 percent for rural poor.[27] Also, attendance for antenatal care initially declined in some districts and urban hospitals serving poor populations following fee increases in 1994, but it subsequently recovered in most districts. The major negative consequences of the fee increases seem to be: (i) low-income women are waiting to begin antenatal care, either to save money or to ensure the pregnancy will reach full term; and (ii) the financial burden on poor households. This indicates that the analysis of the impact of user fees on the poor should not only consider its consequence on the quantity of services consumed but that is should also analyze its financial impact on households as well as the changes it might introduce in the health care seeking behavior (type of services consumed, timing of visits). The same survey indicates that the percentage of births in health facilities has not changed since 198[?]. The 1994 DHS found that 91 percent of urban women and 61 percent of rural women delivered at a health facility, virtually the same as found in the 1988 DHS (CSO 1988, 1995). Yet a study by Lennock (1994) shows that following stricter enforcement of charges, maternity admissions at Harare Central Hospital Maternity unit showed a 21 percent increase in the number of babies 'born before arrival' and later required admission due to problems; among these babies mortality rose 156 percent. According to Lennock cost was one of the major reasons for giving birth at home and for requesting early discharge after delivery. Many people do not seek care because they are unaware that they are exempt from fees. Moreover, prescription costs lead to discontinuation of treatment. District outpatient attendance has declined following increased fee enforcement, with the greatest declines among children. For children under 5 it fell by 30 percent from 1990 to 1992, which coincided with increased fees in 1991 and decreased incomes from the 1992 drought. Attendance rose sharply following the removing of rural fees in 1995, but average under-5 outpatient attendance rates are still below 1990 levels. In contrast, adult attendance fell only 20 percent over those two years and by 1996 was 20 percent above 1990 levels. In hospitals serving low-income populations, inpatient attendance dropped following fee increases, then recovered.

A study by Hongoro and the MOH (Hongoro, 1994) shows that in rural facilities health care demand increased after fees were abolished in 1995. Loewenson (2000) found that 6 months into the elimination of fees, demand fell again as the inventories of drugs and medical supplies dwindled leading patients to bypass primary care facilities and seek care directly from the fee-charging district-level hospitals. There is evidence of people's willingness to pay fees when they felt that payment would give them access to quality services. Communities in Zimbabwe have in fact mobilized resources in many different ways such as in kind contribution of labor and food donation. In the case of rural Zimbabwe, exempting the rural poor from payments was an ineffective way of protecting the poor, as the exemption resulted in a drop in quality of care. Loewenson (2000) noted:

> "People no longer accepted political messages of 'free health services' when services were collapsing [and] were willing to make fair contributions."

Total cost recovery from fees was low but increased substantially when facilities were allowed to retain fees. Since then, it has stagnated at below 5 percent of the recurrent health budget (Loewenson, 2000). Increased fees were criticized for not being associated with better quality services, especially when patients where charged irrespective of whether drugs or other supplies were provided to them. In the urban area[28] where protection mechanisms were supposedly in place to protect the poor against user fees,

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[26] A summary of this evidence can be found in World Bank, 1998a

[27] Reference is made to the urban poor as fees had been abolished in rural facilities at this time.

[28] User fees were abolished in rural areas in the mid 1990s.

about 40 percent of the urban poor stated that the reason for not seeking health care at government facilities was the high price of services (Loewenson, 2000).

Also, many poor people did not apply to program waivers because either they had not heard of the SDF or they did not know how to apply for waivers. By late 1993 only around one-half of the population had heard about the possibility of getting waivers through the SDF (Watkins, 1997). Many eligible persons seemed unwilling to apply because of the stigma associated with welfare benefits. Overall, only 20 percent of the urban poor and 10 percent of the rural poor received assistance with health fees (World Bank, 1998a). There is anecdotal evidence suggesting that some waivers were granted on the basis of political preference (e.g., depending on who was the political candidate favored by the applicant in the latest election). Finally, health facilities were often reluctant to grant waivers as reimbursement mechanisms for waivers and exemptions did not work adequately.

(e) Lessons learned

The following are main lessons emerging from Zimbabwe's experience with protection of the poor under user fees:

- The setting up of a fund to compensate facilities for exemptions and waivers does not suffice to confer incentives to the providers for exempting the poor. Among the most important reasons are: lack of funding; delay in reimbursements of revenue loss due to waivers and exemptions and high costs associated with labor-intensive bureaucratic procedures.

- High participation costs discourage the poor from applying for a waiver.

- Limited information about the program and its benefits among prospective beneficiaries hampers the effectiveness of the exemption system.

- The abolishment of user fees may not boost demand among the poor when it is accompanied by a drop in quality.

- The income criterion is difficult to apply in a country where most work in the informal sector, have irregular income, and there are no information systems that might help to establish applicant eligibility.

- The income criteria have to be adjusted to changing economic conditions.

3.6 Indonesia: The *Kartu Sehat* Program[29]

(a) Background

With a population of 206 million in 2001, Indonesia is the world's fifth most populated nation, after China, Russia, the United States and India. The country enjoyed remarkable economic growth in the 1980s and much of the 1990s. As a result, Indonesia's middle class grew considerably, but poverty remained widespread. Indonesia plunged into an economic crisis in 1997 that led to significant political changes and increased the vulnerability of the poor.

[29] Unless otherwise noted, the information for this case comes from Gibbons 1995, Saadah *et al*, 2001, Sumarto *et al.*, 2001, Ausaid v2000, Saddah, 2001, and SMERU, 2000

About one quarter of Indonesia's population lives below the national poverty line. In an effort to expand coverage of health services for the poor, since the early 1970s the government has promoted the expansion of public health centers and sub-centers. In the late 1970s, the probability of seeking modern treatment by the poor when ill was less than 40 percent; by 1987 it had increased to 52 percent. These gains, however, have been reverted by Indonesia's sharp drop in income during the current economic crisis.

(b) User-fee policy

A major expansion and strengthening of the government's primary health system in the 1980s strained the public budget for health and led to the government's decision in the early 1990s to increase reliance on user fee revenue for health financing. Facilities can only retain part of the revenue collected from user fees. In some places, health centers can keep 25 percent of the revenue collected; the balance is distributed with the budget allocation from the province (Newbrander, 2001). Fees seem to be quite low, they vary according to the level of care and across the country, and they are generally higher at higher levels of care. A RAND study analyzing the impact of user fees on access concluded that the higher prices led to decreased utilization of modern health care facilities, especially by low-income families. It also found that many of the poor would exit the formal medical care market in response to higher fees. Although to date fees remain low compared to cost, they are unaffordable to many of the poor, particularly for inpatient care. Private expenditure represents almost 65 percent of total health expenditure and out-of-pocket payments by patients finance nearly one-half of all spending in the public sector.

(c) Protection policy

Indonesia combines different mechanisms to protect the poor under user fees. *Surat Miskin* or "poor letters" are given to persons who cannot afford to pay the full cost of services. To obtain this waiver, the poor have to go to the village head and sub-district officials for signed approvals. Government health facilities grant total or partial waivers to patients holding a *Surat Miskin*. Very few people seem to be using *Surat Miskin*, however, owing to the complicated administrative requirements and high travel costs associated with them. Also, government officials often charge additional fees in exchange for their signature of the necessary documents. Free care is traditionally given to people who work as volunteers in the village posts that deliver child health and prenatal care services.

Since 1994, in an effort to mitigate the adverse effect of user fees on the poor, Indonesia adopted the *Kartu Sehat* Program, an initiative that continues to function today and that has received additional impetus during the recent economic crisis of South East Asia.[30] The program is intended to cover all poor families in the country. It distributes cards which entitle the recipients to obtain free services in all government health facilities. A single card is handed out to each recipient family, and up to eight family members can be listed on the card. Cardholders needing health care must first go to a government health center. For further, higher-level care, the health facility must issue a referral letter entitling the patient to guaranteed free access in public hospitals. Until recently public facilities had to absorb the revenue foregone from this free-care policy. Since 1998, however, service providers are compensated for the additional workload through a governmental budget transfer that is established on the basis of the number of card holders living in the district (Cameron, 2000).

Kartu Sehat cards follow a long bureaucratic journey until they reach the individual recipients. They originate at the provincial level of government and move down the decentralization path.[31] Each

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[30] *Kartu Sehat* means "exemption card" in Indonesian

[31] There are 32 provinces and 357 districts (regencies).

provincial MOH distributes cards to the head of the district government, which in turns forwards the cards to the head of its poor sub-districts. Within each sub-district, priority is given to those villages identified as being the poorest (also known as IDT villages or "left behind" villages), based on information from the Central Bureau of Statistics. From there, cards are allocated to the heads of low-income villages, and then to the head of the sub-villages where cards are finally handed out to the poorest households (village heads or health center staff selects recipient households from a list containing all poor households in the poor villages). Originally, different villages used different types of information to select the poor. Some use the so-called "*Dinas* Social list" of all poor households in the IDT villages; others select households according to their socioeconomic status (Gibbons, 1995). The process of selecting the poorest is made by the village or neighborhood head (World Bank, 2000).

Kartu Sehat has received a major impetus with the Social Safety Net Program that was introduced by the government in the late 1990s to combat the impact of the economic crisis. Still it was recognized that the scheme was not functioning as envisaged. At most, card holders obtained free services at *Puskesmas* (health centers), but rarely did the services extend to hospitals or to delivery services for pregnant women. With the adoption of mechanism to compensate providers for waivers given in the late 1980s access to health services by the poor improved. Further, *Kartu Sehat* now puts greater pressure on providers to play an active role in administering the scheme, including the process of identification of poor families. Providers participating in the program are also expected to recording details about beneficiaries and to issue the program cards (Ausaid, 2000). Also, eligibility criteria have been modified. The poverty measure currently in use to determine eligibility is the so called household "prosperity status". Under this new policy a household is deemed eligible for the health card if it fails to meet any of the following criteria (Sumarto S, Suryahadi, A, 2001):

- All household members are able to practice their religious principles.
- Al household members are able to eat basic food twice a day.
- All household members have different sets of clothing for home, work, school and home.
- The largest floor area of the house is not made of dirt.
- The household is able to seek modern medical assistance for sick children and family planning services.

The National Family Planning Board collects information on this issue. The task of selecting beneficiaries is now handled by local teams that must operate within program guidelines but which still have substantial discretion in defining eligibility

(d) Results

The *Kartu Sehat* program is rapidly increasing its coverage. Data from a nationwide household survey (Susena, 1999) indicates that 10.6 percent of Indonesian households report ownership of a health card (Saadah and Pradhan, 2001).[32] Data from the Central Independent Monitoring Unit (CIMU) is even more promising as it found that by July 2000, in 5 provinces being closely monitored, 89 percent of all poor families were *Kartu Sehat* beneficiaries; only about 10 percent of all covered were non-poor (leakage); and over 70 percent of pregnant women in poor households had received ante-natal care and assistance during delivery (World Bank, 2000). However, there is information that indicates much higher levels of leakage than indicated by CIMU. According to the 1999 National Household Survey, about 39 percent of the health cards were owned by household from the wealthiest three quintiles (Saadah and Pradhan, 2001).

[32] Each card covers an entire household

The presumption about high leakage has been confirmed in a study by Sumarto *et al.* (2001). These authors found that the proportion of those belonging to the poorest quintile using health cards to obtain program benefits was 10.6 percent while the equivalent proportion among the non-poor was 5.3 percent (Table 17). Leakage may partly be explained by the fact that the income criteria used by Kartu Sehat may not adequately capture poverty. Sumarto (2001) used household survey data to simulate the target population with the current income criteria and compared it with the population that would be eligible if the national consumption based poverty line would be used instead. They also found that 38 percent of those who are according to the national poverty line are not eligible for *Kartu Sehat* according to the official eligibility criteria. On the other hand, 46 percent of the non-poor households were eligible and 38 percent of the poor were not eligible (Sumarto, 2001)

Several studies question the effectiveness of *Kartu Sehat* as many health card owners do not seem to use them when seeking care from a public provider (Saadah, Pradhan , 2001 and Cameron, 2000). Soelaksono *et al.* (1999, quoted in Saadah and Pradhan, 2001) mention among the reasons for this behavior a lower quality of service for health card users (for example less time allocated to patients). According to the same authors, health card holders confirm this situation: they perceive the care received through the health card to be of lower quality than services obtained when not using the card. This situation may be explained by the fact that providers are paid on a lump sum basis rather than on a case-based or other volume-related form of provider payment.

Table 16 Indonesia: Relationship between *Kartu Sehat* eligibility criteria and income-based poverty criterion, 2000

		Consumption-based measure of poverty		
		Poor	Non-poor	Total
Kartu Sehat eligibility criteria	Eligible	15% (62%)	85% (46%)	100%
	Non-eligible	25% (38%)	75% (64%)	100%
	Total	(100%)	(100%)	

Source Sumarto, 2001

Table 17 Indonesia: Coverage of social safety net programs across expenditure quintiles

Program	Eligible Recipients	Program Coverage ([percent?]) Poor Q_1	Q_2	Non-Poor Q_3	Q_4	Q_5	Total	Total Q_1 - Q_5	Ratio Non-poor to Poor
Subsidized Rice	50,385,444	52 64	46.24	41 71	35 76	24 33	36 90	40.09	0 70
Employment Creation	50,385,444	8 31	6 89	5 79	4 58	2 53	4 94	5.61	0 59
Primary School Scholarships	29,745,369	5 80	4 84	4 02	3 52	2 04	3 60	4.03	0 62
Lower Secondary School Scholarships	10,394,621	12 15	10 31	8 34	6 73	4 85	4 53	8 42	0 62
Upper Secondary School Scholarships	6,430,146	5 40	5 06	3 32	3 04	1 96	3.32	3.71	0 62
Medical Services	***27,567,138***	***10.60***	***7.24***	***6.3***	***4.52***	***3.09***	***5.28***	***6.33***	***0.50***
Nutrition	19,970,948	16 54	16.64	16 38	15 94	14 24	15.94	15 94	0 95

Source Sumarto 2000.

Kartu Sehat has experienced several implementation problems that might be of interest to other countries wishing to implement similar poor-protection mechanisms. One of the problems has been widespread lack of knowledge about the program by both health facility personnel and patients. A newsletter evaluating the program states:

> "Too many people remain confused or simply do not know how the Health Card scheme is intended to work Who is entitled to receive a card? What benefits does it provide? Which members are covered and for how long?" (SMERU, 2000)

Also, in the first years of implementation knowledge about the program among public officials varied widely from region to region.[33] For example, in a 1995 field study from district health officers in the province of Daerah Istimewah Yogyakarta (DIY) received clear implementation instructions and criteria for the selection of poor households from local lists. In contrast, in the province of Nusa Tenggara Barat (NTB) the implementation procedures were unclear and program staff was unable to implement *Kartu Sehat* (Gibbons, 1995). According to the same study, health service providers also had limited knowledge about *Kartu Sehat*. Most health staff participating in a survey about the program were not aware that beneficiaries referred to hospitals were also entitled to free care in those facilities.

(e) Lessons learned

The following are identified as the most critical findings in Program implementation of *Kartu Sehat*:

- Lack of information by consumers, providers, and government officials and insufficient training have been two major problems encountered in the implementation of *Kartu Sehat.*

- Cumbersome distribution of *Kartu Sehat* cards from higher to lower levels of government not only means high administrative costs but also leads to delay and retention of cards. This issue illustrates that national program implementation can be very challenging in very large and decentralized countries.

- Eligibility criteria fail to adequately capture the poor as many non-poor (as measured by the national poverty line) are eligible and many poor are not eligible for Kartu Sehat.

- The Indonesia case illustrates the importance of reimbursing facilities for revenue foregone from waivers. Program coverage has increased substantially when facilities started to get compensated for waivers given under *Kartu Sehat.*

- Coverage is an insufficient measure of protection of the poor. In Indonesia many poor do have a health card but they do not use it as perceived quality of services is sometimes low.

3.7 Thailand's Low Income Card Scheme (LICS)[34]

(a) Context

Thailand went through a period of remarkable economic growth in the 1980s and 1990s that made it one of the fastest growing economies of South East Asia and the world, with an average annual GDP growth of 9.1 percent from 1986 to 1996. Thailand's population of 62.4 million has a life expectancy at birth (LEB) of 68.6 years –three more years than Indonesia and about 1.5 years less than China. As most regional economies, Thailand started to experience a severe economic crisis in the late nineties. Poverty has increased as a consequence although not to the extent seen in other countries in the region, such as Indonesia and Korea

The economic crisis also drastically changed the health financing scenario. The per capita government budget for the Ministry of Public Health (MOPH) declined by 25 percent in real terms between 1997 and 1999. The MOPH responded by cutting capital expenditure, rationalizing the use and procurement of drugs, and reducing expenditure for utilities and travel. Benefits under the Civil Servants Medical

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[33]. No up to date information was available on this issue when this report was being written

[34] Based mainly on Gilson *et al.*, 1998, Donaldson, 1999 and Somchai 1998

Benefits Scheme were restricted to care from public sector facilities. In addition, between 1996 and 1998 household annual health expenditures on health facility-based care declined sharply –by 36 percent in real terms (to 2,316 baht).[35] At the same time, household spending on self-medication increased by 12 percent (to 552 baht). This change in patient behavior reversed a long-term trend away from self-treatment towards treatment by trained health providers (NESDB, 2000).

A wide range of insurance or benefit schemes are available to the Thai population. The five major systems are: the Civil Servants Medical Benefits Scheme (CSMBS), a Social Security Scheme (SSS), the Voluntary Health Card Scheme (VHCS), the Low Income Card Scheme (LICS) and commercial private health insurance (Table 18). Together, they provide protection to about 76 percent of the population. The poor and near poor are protected by LICS (see details below) and VHCS (Table 19). VHCS covers near-poor households as well, mostly in rural areas. Beneficiaries can voluntarily buy a card which attracts a matching tax subsidy and which gives them access to free care at public facilities.

Table 18 Thailand: Characteristics of health insurance schemes, circa 2000

Insurance Program	Nature of Scheme	Coverage (millions)	Coverage (percent)	Population Characteristics	Source of Funds	Financing Body
CSMBS	Employment Benefit	6,6	11	Civil Servants	MOPH Fund	MOF
SSS	Compulsory	4,8	8	Employees in Firms Larger than 10 Persons	Tripartite contributions (MOPH, employer, employee, 1,50% of wages[36]	Social Security Organization
VHCS	Voluntary	6,0	10	Near Poor	MOPH Fund	Ministry of Health
LICS	Social Welfare	27	45	*Indigent, Children <* 12, Elderly, Veterans, Handicapped, Religious & Community Leaders	MOPH Fund	Ministry of Health
Private	Voluntary	1,2	2	Richest segment of the population	Premium	Households
Total		50,4	76			

Source Donaldson *et al*, 1999

Table 19 Thailand: Coverage of LICS and VHCS

Insurance Program	Ambulatory	Inpatient	Provider Choice	Maternity	Prevention Promotion	Services not Covered
VHCS	Public	Public	Requires Referral	Yes	Possible	Pvt Bed
LICS	Public	Public	Requires Referral	Yes	Limited	Special RN Pvt Bed

Source: Donaldson *et al*, 1999

(b) User Fee Policy [37]

Thailand has a long standing user fee policy in the public sector implemented with clear policy guidelines since 1976-77; it raises a significant amount of revenue. A rough estimate indicates that, on average, about 60 percent of Ministry of Public Health (MPH) hospital's total revenue comes from the

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35 [Provide exchange rate]

36. Due to the economic crisis, this percentage was reduced to 1.0% after 1998 (see Donaldson et *al* 1999)

37. Taken from: Health Care Reform Project Thailand on: http //www moph go th/ops/hcrp/mainhcrp php?select=Finance html

government's allocation and 40 percent from user charges. Of this user fee revenue, approximately one-third is collected from patients on a fee-for-service basis (mostly from the sales of drugs), and the remainder comes from reimbursements from insurance plans. Often a major portion of hospital payments comes from the civil servant benefit schemes which cover many of the hospitalized patients and which pay hospitals their full fee. In health centers, user fees may account for as much as 70 percent of total revenue. Health centers provide an average of 3,644 visits per year, half of which for patients covered by the free care program. User fees are collected mainly from the sale of drugs. Hospitals and health centers set their charges on a sliding scale, and have the discretion to decide how much to charge patients based on the provider's assessment of their ability to pay. Patients covered under insurance plans, such as civil servants and their dependents, are often charged a higher price –two to three times the lowest price.

(c) Protection mechanism

To protect the poor against the financial burden of user fees, the government developed the Low Income Card Scheme (LICS) under which the poor have free access to public facilities. Thailand has over twenty years of experience with LICS as operations started in 1975.

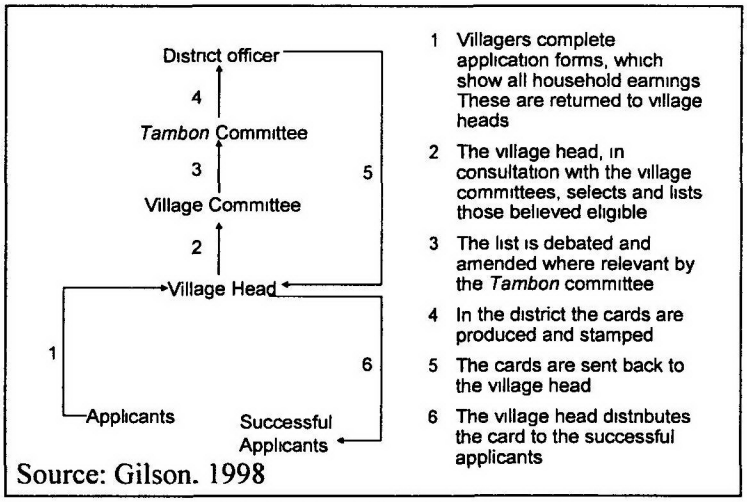
Table 20 Thailand: National poverty line and cut off points for LICS

	1988-89	1993-94	1997-98
National per capita poverty line per month1	473	636	911
Cut off point for a single/month	1500	2000	2000

Source: Donaldson, 1999, and based on Somchai

At the beginning of LICS, the directors of public hospitals had the authority to screen the beneficiaries and grant exemptions to the poor on their own criteria. Different cash incomes cutoff points have been used to determine applicant eligibility. Since 1993, eligible beneficiaries are single persons with a monthly income of less than 2,000 baht ($47) and households with a combined monthly income of less than 2,800 baht ($66).[38] Cutoff points were neither differentiated for urban and rural settings nor updated on a regular basis. Table 20 compares cutoff points of eligibility for LICS with national poverty lines for several years. As the income level for being entitled to the LICS systematically exceeds the poverty line, the program potentially covers not only the poor but also the near poor.

Figure 11 Thailand: Official procedures for screening the poor, 1981



Source: Gilson. 1998

During the 1990s LICS eligibility was expanded to include not only the income poor but also other groups, including the elderly, children below 12, veterans, the handicapped, and monks. With this expansion, LICS changed its name from the medical welfare scheme for the low-income to the medical welfare scheme for underprivileged groups.

The other major set of changes introduced in the implementation of LICS concerns the dissemination of information on the LICS allocation process, as lack of information was considered a major obstacle to coverage of the poorest. Accordingly the village head was given a more active role in the application procedure: he was made responsible for announcing the scheme one month

[38] Exchange rate June 2002, 42 31 baht/dollar

before the deadline for application and for conducting a house to house survey to ask people to complete their applications.

The identification of the poor is conducted at the community level, primarily by village and *Tambon* (sub district) leaders. The official procedure for screening the poor that was introduced in 1981 is depicted in Figure 11.[39] A committee headed by the village leader examines the application forms that are submitted by applicants. Then a preliminary list of beneficiaries is produced by the village head in conjunction with the village committee. This list is then screened and amended by the sub district level. Since its implementation in 1981, the participation of the community in the screening procedures has been gradually strengthened by adding new members to the village committee. Most importantly, health workers were included in the screening process as it was argued that committee members from outside of the health sector did not understand well enough LICS procedures. Also, there was much concern that the village leaders might allocate cards according to their own criteria or needs. Finally, the power of the village head was further counterbalanced by a regulation introduced in 1987 whereby the person responsible for the *Tambon* health center checked the list of eligible candidates drawn up by each village in the *Tambon* and by adding new local actors to improve judgments about eligibility.

People who qualify are given a beneficiary card valid for three years. The card specifies one or two designated health facilities –normally, they are local health centers or district hospitals– for beneficiaries to visit in case of illness or injury. The program requires beneficiaries to seek medical care from the *Tambon* health center as a first point of entry into the system. Health center staff will then determine whether to refer patients for which they will be provided with free care. For emergencies, eligible cardholders can go to any public facility (Somchai, [year?]). Under the free care program, poor individuals who do not hold a card are classified by an ad hoc procedure on arrival at the government facility and exempted totally or partially from fees.[40]

Special funds are set aside to compensate facilities for waived services. A budget is allocated to the provincial level and is financed through general revenue. The Government of Thailand (GOT) has used a number of criteria for allocating the LICS budget to provinces, including population size, number of health facilities, and number of card holders, standardized mortality ratios, and workload.

LICS has undergone modifications that reflect difficulties experienced with targeting. Several revisions have focused on strengthening community based screening processes involving a wider range of key participants and in particular village volunteers (Gilson *et al.*, 1998). More recently Thailand has introduced radical changes in health policy, with a shift towards universal health insurance coverage. VHCS and LICS are to be substituted gradually by the so called "30 Baht health policy" launched in February 2001. With the new policy all uninsured citizens would receive a universal health card. Individuals must produce this new card when seeking care in either public or private facilities registered with the government for this initiative, along with some other individual identification. The accessing health service has to follow the referral system from the primary health center or the nearby hospital. For emergencies and accidents, the insured can access any government health services. All beneficiaries must contribute a copayment of 30 Baht ($0.71) per visit.[41] The 30 Baht Universal Coverage Policy, the insured will receive a predefined package of health services, which includes most health services except cosmetic care, obstetric delivery beyond two pregnancies, drug addiction treatment, hemodialysis, organ transplantation, infertility treatment, and other high cost interventions. From the government side, the funding of the system is paid by capitation. The annual per capita payment, which comes from general tax revenue is 1,404 Baht, part of which is paid to the health care facilities according to the number of

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[39]. Gilson *et al.* 1998.

[40] They are called Type "B" patients, distinguishing them from Type "A" patients.

[41]. Exchange rate in June 2002: 42.31 baht = $1 00.

cardholders registered with them (APHEN, 2001; The Nation 2002). Since this new scheme was just started evaluation is still lacking. Main concerns raised by analysts are insufficient funding to finance the scheme, incentives for facilities to avoid the provision of high cost and incentives to switch to the 30 baht health card for people insured under other systems (The Nation 2002). It is worth mentioning that more recently Thailand has opted away from mechanisms specifically focused on exempting the poor from user fees and has instead started to promote a scheme under which all the non insured Thai are eligible for coverage against paying a moderate copayment (30 baht) per episode. The financial viability of this scheme remains to be seen as it might create incentives for the insured to switch to this system.

(d) Results[42]

In 1998, the numbers of beneficiaries of all categories (low income, elderly, handicapped etc.) was approximately 17.6 million or 29 percent of the population. Low income card holders represented approximately 5.8 million of total beneficiaries (Table 21). According to a more recent source, by the year 2000 LICS covered as much as 37 percent of the total population (Tangcharoensathien 2001).

Data on coverage of the target groups and leakage to non eligible beneficiaries varies. According to studies by Supachutikul (1996) and Mongkolsmai (1993), in the early 1990s coverage of the Ministry of Health target group (people below income cut off points) was equal to about 76 percent. Also coverage of the poor living below the national poverty line appears to have increased from the range 30 percent-40 percent in the late 1980s to around 80 percent in the early 1990s. This sharp increase in coverage is not confirmed by all studies. According to research by the National Institute of Development Assistance, NIDA, serious problems exist with respect to both coverage and leakage. A survey showed that about one-third of responding households were poor, and only 32 percent of them had the low-income cards. Furthermore, there seem to be problems of leakage as only 55 percent were poor according to the family income criteria (Sriracha Charoenparij, et al., 1999). Leakage of benefits to the non-poor may reflect the fact that official eligibility income criteria are above the official poverty line and therefore many of the non-poor are included in LICS's target population.

Additionally, it seems that LICS beneficiaries are not always sufficiently well protected from health care payments. A 1993 study found that that those holding the LICS spent 6.1 percentof annual income on health as compared to the 0.6 percent to 2.3 percent spent by other insured groups (Pannarunothai and Mills, 1993). Various studies explain this situation with data indicating that LICS cardholders often do not use their card to access services and prefer to pay rather than to receive free services under LIC. As has been already illustrated by *Kartu Sehat* in Indonesia, this is a situation that seems to apply not only to Thailand. High coverage of documents certifying eligibility for exemptions does not seem to be a proof of effectiveness of protection mechanisms.

Table 21 Thailand: Number of low-income cardholders by region, 1981-1998 (millions)

	1981	1984	1987	1990	1993	1998[1]	1998[2]
Central	1.84	1 66	1 29	1 82	1 82	0 75	3.24
Northeast	4 99	4.52	3.50	5.57	5 57	2 97	8 14
North	2.97	2.72	1.85	2.39	2 39	1.40	3.94
South	1.10	1.23	978	1 64	1 64	0,69	2 33
Bangkok	0.00	0,03	0,022	0,08	0,08	0,02	0 03
Total	10.89	10 16	7 64	11.50	11 82	5 79	17 67

Source. Charoenparij *et al*, 1999 based on data from the Rural Health Division, MOPH, Thailand.
Notes:
[1] Reported Figures for the low-income cards issued in 1998
[2] Reported figures for all types of cards issued to the underprivileged (low income and other groups)

[42]. Discussion is limited to LIC as the "30 baht policy" is still in its first months of implementation.

The budget set aside to cover exemptions for card holders and other poor patients has increased five fold in real terms between 1988 and 1997 (Table 22). It is however estimated that it is below the amount of revenue foregone due to exemptions. According to a study by Donaldson (1999), in 1997, the budget was about 30 percent below expenditure for exempted patients. The remainder was cross-subsidized from each hospital's own revenue generated from user charges and insurance plans (Table 23).

The problem of inadequate funding is worsened by a problem of inequitable geographic allocations where wealthier regions seem to receive higher per capita allocations than poorer regions (Table 24) even though the situation has improved as the allocation has come closer to a capitation based formula.

Table 22 Thailand: Resources for LICS, 1988-97

Year	Number of people covered by the program (million)	Budget in current prices (million baht)	Budget in 1993 prices (million baht)
1988	7 65	706	901
1989	7 65	800	936
1990	10 73	1,500	1,736
1991	10 73	2,000	2,205
1992	11.70	2,500	2,625
1993	11 70	2,750	2,750
1994	11.80	4,273	3,876
1995	11.80	4,475	4,059
1996	14 00	5,706	4,929
1997	15 00	6,703	5,515

Source Somchai Suksirserekul, 1998 based on database of office of health insurance

Gilson *et al.* (1998) carried out community based field research which showed that the card is greatly valued by the people because "it protects the poorest against the cost of both minor and more serious illness and for higher income groups it provides a safety net: free access to government care in cases of expensive chronic or serious illnesses, or illnesses not effectively treated by other providers." Despite these successes Gilson and her colleagues identified various obstacles to further success of LIC among which:

- The multiple vulnerabilities and marginal situation of the poor which makes it difficult to reach them: they tend to live further off and work longer hours, making it more difficult to disseminate the information and to persuade them to apply for the health card.

"I've never been issued an LICS card. I've never come across any messages on it. Anyway, it could be possible that my house is isolated from the rest of the community and I don't have much time to chat with neighbors. I've been working as an aide for an old, long-term patient from 7 o'clock in the morning till 6 or 7 o'clock in the afternoon.. I might be too busy to get messages." (Gilson *et al.*, 1998)

- The difficulty in using formal income criteria, when most of applicants belong to the informal sector, are highly mobile, and receive some in-kind income.
- Use of the power to allocate cards for personal favors and political purposes.

Table 23 Thailand: Budget and expenditure of the LIC, 1987-1997

Year	Resources allocated to finance exemptions	Loss due to exemptions
1987	705,839,500	2,051,856,237
1991	2,000,000,000	2,345,067,875
1997[43]	6,370,524,000	9,018,341,515

Source. Donaldson 1999
Note. Expenditures are not true measures of costs of service, rather of the charges not paid by LICS patients

- A negative perception of public service quality by the poor and many cardholders prefer not to use LICS

[43] Note that the numbers quoted by Somchai Suksirserekul, 1998, do not coincide with the information contained in the report by Donaldson 1999

Table 24. Thailand: LICS per capita budget allocation by region (baht), 1992-1999

	1994	1996	1998	1999
Northeast	132	140	205	264
North	194	193	263	306
South	323	160	239	273
Central	539	183	258	316
Central Northeast	4 08 . 1 00	1 38 : 1 00	1 16 : 1 00	1.20 . 1 00

Source:

- Insufficient funding (as confirmed by the data contained in Table 23). Poor experience with cost and quality of service provided under LIC discourages some low income people to apply for the card and use it to obtain health care.

"I never got free drugs. I had to pay every visit"

"Since I got the card, I have never used it. I did not know when and how to use the card. I hear that clients using the card would obtain only low quality drugs and had to wait longer. Clients who pay for treatment would get the service first. I prefer buying drugs. Having LIC was good but it also has disadvantages. My sister in law used it at the hospital They did not pay attention to us. They thought we did not have money, they paid less attention to us.. "(Gilson et al., 1998).

- Stigmatization of the poor, which deters some card holders from using their rights under LICS. Low income card holders feel that health workers discouraged them from using their cards , making them feel inferior and embarrassed.

"Sometimes I self-treat because I do not want [the health worker] to complain that I often get free drugs from the health centre" (*Ibid.*)

(e) Lessons learned

Thailand's overall record is quite outstanding when compared to most other countries. First of all, Thailand's LICs covers possibly as much as 80 percent of its target population and, as has been shown by the study of Gilson and colleagues (1998), the card is greatly valued by many beneficiaries. Also, the extensive experience with the program has allowed the government to gradually strengthen LICS by increasing community participation, changing income cutoff points, increasing funds to reimburse institutions, adjusting formulas to allocate resources meant to cover expenses and, more recently, by reconsidering the criteria to identify the poor.

As was noted, only about 13 percent of the Thai population, or 7.9 million people, live below the national poverty line (Somchai 1998). Yet by the year 2000 LICS had reached about 37 percent of the total population. Thus, the number of program beneficiaries greatly exceeds the number of poor people in the country. Coverage reaches not only part of the poor but also many non poor. This is mainly explained by the adoption of an eligibility threshold that stands above the poverty line and by the inclusion of other groups (among which children below 12 and monks) many of which might not be poor. It remains an open question whether Thailand should try to limit LICS to the poorest by redefining its cut off points or even replacing them by other poverty proxies. Better targeting would allow the program to provide more funding for exemptions and might thereby improve quality of services given to LICS patients. As regards the implementation process the following are some lessons:

- The effectiveness of a protection system cannot be measured in terms of leakage and coverage only. It is crucial that beneficiaries actually access the free services.

- Users may prefer to pay for health services rather than receive low quality services.

- The multiple dimensions of vulnerability of the poor require careful design of the protection mechanisms.

- It is difficult to assess an applicant's income level as they usually work in the informal sector, have irregular and mobile jobs, and receive some income in-kind.

- When designing screening bodies to identify the beneficiary population, careful consideration has to be given to skills and incentives of its members. The Thai experience shows that community leaders had incentives to allocate exemptions to pay personal and political favors and lacked the skills to identify the poor by themselves.

- Uncompensated free care created incentives to provide low quality services.

- Geographic allocation formulas of budget influence effectiveness of protection mechanisms.

- Thailand has made irregular and sporadic adjustments to its income cut off points. Adjusting them according to changes (for example inflation) seems to be highly desirable.

- Lack of consistency between eligibility criteria and the national poverty lines can create serious problems. In the case of Thailand it has led to substantial leakage of program benefits as many card holders are not poor but are eligible for a health card.

3.8 Chile's Nacional Health Fund[44]

(a) Context

Chile is an upper middle-income country that exhibits some of the best health status indicators both among Latin American countries and among countries in its income category. With a life expectancy at birth of 75 years, infant mortality of 10 per thousand life births, and annual per capita income of $8.440 (PPP-adjusted), Chile is the richest country in the case study sample, and the one with the best health indicators.

Chile has a mixed health care system, with both financing and production in public and private hands. Health insurance coverage is mandatory for formal sector workers who, according to a law passed in 1981, have to devote 7 percent of their payroll either for public or private health insurance. There is a single, large public insurer known as the National Health Fund (*Fondo Nacional de Salud,* FONASA), and there are multiple, competing private health insurers known as *Instituciones de Salud Previsional* (ISAPREs), as well as traditional commercial indemnity insurance firms.

In principle, all Chileans are free to choose between FONASA and the ISAPREs. In practice, however, it is a person's level of income and age that determines whether he or she becomes affiliated with the public insurer or with one of the several ISAPREs. FONASA covers middle, lower-middle, and low income people, whereas ISAPREs cover middle, upper-middle, and high income individuals. Also, the active or retired elderly are often unable to enter the ISAPRE system owing to the high premiums that they face; many choose to enroll in FONASA.

Approximately three fourths of the population is covered by FONASA and one-fourth by the ISAPREs. FONASA receives about 40 percent of its funding through subsidies from the national treasury and 60 percent through contributions by beneficiaries. Contributions consist mainly of the 7 percent social

[44] This case is based on Bitran (2000) and on information provided directly by current and former FONASA officers

insurance payroll withholdings and to a much lesser extent of co-payments made by patients in government health facilities. The ISAPREs are self-financed through the 7 percent payroll deductions and additional contributions made by voluntary members. Forty percent of FONASA's beneficiaries have been classified as "indigent individuals"; these make neither payroll contributions to FONASA nor payments in public facilities. Health services to them are free of charge but only when obtained from public health facilities. The other 60 percent of those covered by FONASA are known as the contributing affiliates and their dependents. They are those who make their payroll contributions and who, when using public or private facilities, make co-payments that increase with their income.

(b) User fee policy

User fees have been in place in Chile's public hospitals for over two decades now, but they represent only a marginal part of public health facilities' revenue. Bitran *et al.* (2000) estimated that in 1995 user fees revenue in government hospitals accounted for only 11 percent of total revenue. User fee revenue is retained at facilities and can be spent locally according to certain official guidelines.

FONASA pays hospitals for services delivered to its beneficiaries (the indigent and the contributing affiliates) according to a mixed payment system that consists primarily of prospective budgets and to a lesser extent of payment per case resolved (a simplified version of the U.S. Federal Government's *Diagnotic Related Groups*, DRGs). Budgets are calculated according to expected volume of services and historical expenditures. Revenue from user fees supplements hospital income in public hospitals, and therefore these facilities have an incentive to collect fees. This seems to be especially true for tertiary hospitals and for complex procedures where bills can be quite high. Public hospitals have been plagued by chronic deficits and are using resources from user fees to cover part of their financial gap. It would seem, however, that FONASA may be conferring a perverse incentive for fee collection with a recent policy that bridges the financial gap of hospitals with the largest deficits. This situation, together with the administrative costs involved in cost recovery, weakens incentives to collect user fees. A former FONASA official explains:

> "Why should they [public hospital's management] bother if their expenditures get covered [by FONASA] anyway?"

(c) Protection mechanisms

FONASA classifies its beneficiaries into groups, from A to D, according to income and socioeconomic status (Table 25). Group "A" comprises the indigent. These are the unemployed poor or people who, despite having some informal employment or occupation, are deemed poor and thus are entitled to full public subsidies for health care services. Groups B, C, and D are active workers who fall into these groups on the basis of the income. As income goes up, people move from group B, to C, and to D. Their payroll health tax remains a constant 7 percent. There is a limit to the income that is subject to the 7 percent, however, currently equal to about $1,470 per worker per month.[45] Thus, those in group B do not pay any fees in public hospitals but do make the regular payroll tax contribution. Affiliates in groups C and D make their payroll tax contributions and pay user fees in public facilities. In any case, payments made by beneficiaries in groups C and D represent only a small part (20 percent at the most) of the actual cost of care.

Table 25: Chile: Classification of affiliates of the National Health Fund (FONASA)

		Obligations as FONASA beneficiaries	
Group	Eligibility criteria	Payroll tax	User fee in public hospital
"A"	Persons with "lack of resources", beneficiaries of subsidized pensions, beneficiaries of family subsidies (subsidies for children in low income families)	No	No
"B"	Monthly income below national minimum salary and families with more than three dependant household members and monthly income above minimum salary and below 1 46 minimum salaries	Yes	No
"C"	Monthly income above minimum salary and below 1.46 minimum salaries and less than 3 dependents Monthly income above 1 46 minimum salaries and 3 or more dependants	Yes	Yes, 10 percent of cost of service
"D"	Monthly income above 1 46 minimum salaries and less than 3 dependents	Yes	Yes, 20 percent of cost of service

Source. Fonasa, 2002

Identification of the poor is decentralized and is carried out both by municipalities and health facilities. In municipalities clerks are in charge of selecting the poor; in health facilities this responsibility usually belongs to a social worker who subjects potential beneficiaries to an interview for eligibility determination. Interviews are often followed by a home visit, for verification, or to supplement the information already collected from the person. A "free health card" is handed out once indigence status is determined. Poor patients who do not possess a "free health card" are classified on arrival by health facilities. "Lack of resources" is the main eligibility criterion to get a free health card (Group A). There are no specific guidelines for establishing what constitutes "lack of resources" and it is very much up to the judgment of the officer in charge. There is no supervision of this eligibility determination process.

(d) Results[46]

Table 26 presents "actual" and "imputed" number of affiliates according to information from the 2000 CASEN national household survey. Actual status is determined based on the respondent's self-declaration (respondents were required to produce the FONASA card for the survey). A person is considered to be an actual FONASA affiliate if he or she declares to hold a FONASA card. Imputed status was defined as the one the person should have (i.e., the FONASA group where he or she should be) based on poverty status and cash income level. There is almost total coverage of the poor as only 11

[45] This means that the maximum, legally-required payroll contribution is $103 FONASA does not receive more than this amount from anyone ISAPREs, however, are allowed to charge an additional amount above this maximum mandated contribution, if that maximum does not suffice to pay for the premium of a given ISAPRE health plan.

[46] Mainly based on Bitran *et al*, 2000a

percent (15.064) of individuals that should belong to FONASA A group are not covered by any health insurance. Further, even those poor that do not hold a free health card usually obtain free health services quite easily through a means test conducted at the facility, as mentioned earlier.

Table 26: Chile: Self-declared and imputed FONASA group, 2000

Declared FONASA Group	Imputed FONASA group according to CASEN[47]				
	A	B	C	D	Total
A	89,390	529,729	140,514	242,715	1,002,348
B	22,550	647,805	384,794	448,835	1,503,984
C	4,412	139,864	183,343	279,140	606,759
D	3,500	104,790	114,538	520,511	743,339
Unknown	1,856	30,398	22,999	43,231	98,484
Military	184	15,790	12,173	155,513	183,660
ISAPRE	2,283	76,715	92,926	1,182,015	1,353,939
Ninguno	15,064	196,286	71,463	317,603	600,416
Otro	190	4,382	1,996	12,523	19,091
No sabe	610	18,475	10,194	20.834	50,113
Total	140,039	1,764,234	1,034,940	3,222,920	6,162,133

Source. Bitran and Associates based on Casen 2000 household survey

Note FONASA imputed groups are obtained by applying groups defined by FONASA to income information from Casen FONASA A group is imputed by applying the national poverty line to the income data provided in Casen. Table excludes dependents.

Also, FONASA is highly progressive in the delivery of its health benefits. Table 27 shows per capita benefits, contributions, and subsidies for the four FONASA groups from a study based on data from the early nineties (Bitran *et al.* 2000). Per capita benefits for group A and B are substantially higher than benefits of groups C and D, reflecting the more intensive use of FONASA'S network of health facilities by the poorer groups. In other words, there is a progressive inequality in the distribution of benefits in favor of the poor –one that may help to bridge an equity gap in delivery of health services in the country (note that beneficiaries of groups B, C, and D may make use of private, unsubsidized health care, and that this information is not shown in the table). Health financing also seems progressive. As can be seen from the table, per capita contributions increase with income, going from Ch $7,461 for group A to Ch. $70,479 for group D. Progressivity would appear even greater if non-health taxes, such as income and property taxes, were also accounted for in the exercise.

[47] *Imputed* FONASA group refers to the FONASA group *should* belong to according to their income level Declared FONASA group refers to the FONASA group individuals actually belong to according to Casen 2000

Table 27 Chile: Per capita benefits and contributions in FONASA (Ch$ of December 1995)

	FONASA Group					
	A	B	C	D	Total A-D	B, C and D only
Estimated number of beneficiaries	3,664,733	2,806,016	1,050,634	946,484	8,467,867	4,803,134
Benefits						
Primary Care	6,247	4,691	3,388	2,249	4,930	3,925
Secondary Care	7,513	8,134	2,806	2,883	6,617	5,934
Tertiary Care	38,289	31,346	9,261	10,377	29,267	22,383
Subtotal Primary, secondary and tertiary care	*52,049*	*44,170*	*15,455*	*15,509*	*40,814*	*32,241*
Free-Choice Modality	794	11,608	17,927	19,053	8,544	14,457
Pregnancy and Illness Subsidies	932	4,381	5,833	7,401	3,406	5,294
DFL 36 (additional private sector care)	1,507	1,283	438	447	1,182	933
Total benefits	*55,282*	*61,442*	*39,654*	*42,409*	*53,945*	*52,926*
Contributions						
7 Percent Payroll Contributions	6,987	32,851	43,739	55,495	25,539	39,695
Co-payments in Public Facilities	0	0	3,515	3,586	837	1,475
Free Choice Modality Co-payments	475	6,944	10,725	11,398	5,111	8,649
Total contributions	*7,461*	*39,794*	*57,979*	*70,479*	*31,487*	*49,819*

Source Bitran and Associates, 2000. Values are Ch$ at December 1995.

More recently, however, there has been much turmoil when FONASA discovered in 2001 that as many as half a million of the presumed indigent in group A were actually taxpayers who on average made. annual income tax payments above Ch. $3,000,000 (about US$ 4,500). This finding was made possible through an administrative breakthrough whereby FONASA was for the first time granted permission to cross check information on its affiliates with information on income tax contributions from the internal revenue service. This situation is confirmed by results of the 2000 CASEN survey. Table 26 shows that of a total of 1,002,348 self-declared Group A affiliates, only 9 percent are poor according to the national poverty line. Further, almost 40 percent of group A affiliates have income levels that would put them in FONASA' groups C and D. Overall, the number of FONASA beneficiaries in Group A exceeds by a factor of seven the country's population falling below the poverty line. The problem in Chile is clearly related to leakage and not so much to coverage. Some of the factors explaining this situation are the following:

- There are no clear rules regarding what criteria to apply in health facilities when determining poverty. "Lack of resources" is a very vague term. When asking a former official on how they decided on whether a person would be given the "free health card" or not he said:

> "When we [at the hospital] decided on whether someone was to be given the "free health card" or not it depended very much on how much a patient would cry ."

- There are incentives to cheat as Group A patients receive in practice the same benefits as Group B patients even though those in Group A make no contributions of any kind to FONASA while Group B beneficiaries make a monthly contribution equivalent to 7 percent of their monthly income.

- There are no clear incentives to identify the poor correctly. In Chile, municipalities' income is not linked to cost recovery. Also, municipalities are not responsible for the financial performance of public hospitals. Under this condition, municipalities do not have strong incentives to avoid

leakage when identifying the poor and possibly do have incentives to gain political favors by giving "free health cards".

(e) Lessons learned

The implementation of a protection mechanism for the poor in Chile reveals several challenges that are of interest for countries willing to engage in similar processes. Chile has reached almost all of the poor through FONASA and the poor seem to be accessing health services much the same as the richer segments of the population. Problems are associated with leakage and not so much with coverage:

When designing protection mechanisms careful consideration must be given to who determines eligibility. The case of Chile illustrates that countries have to choose entities in charge of determining eligibility in a way that strikes a balance between health facilities interest in collecting revenue and administrative or political entities possible interest to pay favors by allocating cards to the non poor.

When designing protection mechanisms for the poor under user fees, careful attention has to be given to possible incentives created for the contributing richer population. In Chile such incentives clearly exist as the benefits for the indigent and the non poor are the same in practice. Group "A" beneficiaries are completely exempted from payments and get basically the same benefits as Group "B" "C" and "D" beneficiaries which make payroll contributions and pay user fees (with the exception of group "B"). Under this circumstance, strong incentives exist for potential beneficiaries to get classified as Group "A" beneficiaries.

The case of FONASA in Chile illustrates once again the importance of clearly defining the eligibility criteria. In Chile no consensus seems to exist as to how to interpret "lack of resources".

It is crucial to implement effective monitoring mechanisms capable of measuring coverage and tracking problems of leakage. Chile recently made a great leap forward when deciding to cross check its data base of FONASA beneficiaries with the data base of the Tax Administration. It was the integration of data bases that allowed Chile to detect a massive problem of leakage.

4 Lessons and best practice

This final chapter summarizes the findings from case study countries and draws lessons about best practices. Section 4.1 reviews the performance of waiver and exemption systems. Section 4.2 comments on the financing of protection mechanisms and the kinds of health benefits they covered. It also discusses general design and implementation features, particularly those regarding beneficiary eligibility. Sections 4.3 and 4.4 examine design and implementation aspects of waivers and exemptions that influence, respectively, provider behavior (or the supply of waivers and exemptions) and consumer behavior (the demand for waivers and exemptions). Finally, Section 4.5 offers concluding remarks about best practices.

4.1 Performance of waiver and exemption systems

(a) Performance monitoring and evaluation

Performance assessment for all cases studied is hampered by a lack of evaluation. None of the cases reviewed systematically monitors performance in terms of who the beneficiaries of waivers and exemptions are and what is the influence of these protection mechanisms on access and out-of-pocket health spending by the poor. The lack of monitoring is a major weakness of waiver and exemptions systems, as the consequences of these cannot be regularly assessed and the policies thereby evaluated. In all cases performance indicators come from ad-hoc studies. Regular monitoring of pro-poor protection systems should at a minimum, through routine facility recording and via periodic household surveys

- Record exemptions and waivers granted.
- When using individual targeting, establish a data base containing basic information on beneficiaries such as identity number, name, age, sex and geographic location
- Compare actual exemption and waiver levels with targets.
- Estimate coverage and leakage of protection mechanisms.

(b) Targeting methods used

Table 28 describes the targeting, or beneficiary identification method used, and presents a summary of performance indicators, including coverage of the target group, leakage, administrative cost, access to health services by beneficiaries of the protection mechanism, and effect of protection on out-of-pocket health spending ("financial burden").

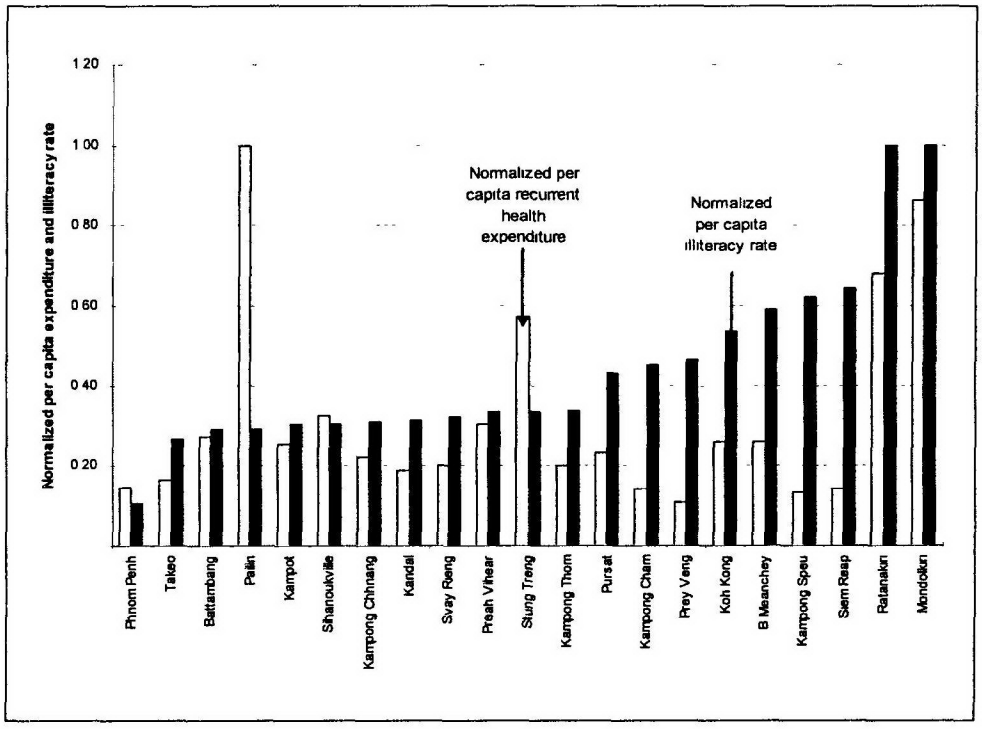
Targeting methods to provide waivers were in some cases a combination of geographic targeting and individual means testing (Kenya, Ghana, Indonesia, Thailand), while in others they were only based on individual means tests (Cambodia, Zimbabwe, and Chile). By combining geographic with individual targeting, some countries, such as Ghana and Zimbabwe, attempted to improve equity in the allocation of public subsidies for health by compensating providers in a system that linked incremental public subsidies to the level of waivers provided. Others, such as Kenya, also combined group and individual targeting but did not accompany the policy of granting waivers by a stream of compensating subsidies. Countries which only use individual targeting, such as Cambodia, could eventually improve equity in the allocation of public subsidies for health if they incorporated geographic targeting criteria.

Table 28 Waivers and exemptions in case study countries: Performance indicators

Country	Targeting system	Performance variable				
		Coverage	Leakage	Administrative cost	Access	Financial burden
Kenya	Group targeting, targeting by type of services and means testing (no clear criteria as to income threshold)	No monitoring, thus no systematic information On average 2 exemptions per month per facility; contrasts with 42% of Kenyans below poverty line	No systematic information. Civil servants, public health workers receive free care	Not available	Not available	Not available
Cambodia	Individual means tests carried out by EF or health facility staff	Overall only 18% of users of health care services were exempted from fees but 36% of population is poor	Low leakage.	Generally high, particularly owing to use of expatriate labor	All EF beneficiaries are entitled to, and obtain, free health care	Beneficiaries of EFs obtain free care, thus financial burden of user fees is relieved
Ghana	Group targeting, targeting by type of service and means testing (no clear criteria regarding income threshold)	No systematic monitoring According to some data, exemptions granted to less than 2% of patients	High leakage in Volta Region. Most exemptions given to health workers, evidence of exemptions to government officials	Not available	Not available	Not available
Zimbabwe	Means testing, income threshold	About 20% of urban poor and 10% of rural poor had received assistance with free care; 25% or population below poverty line	No systematic information. Anecdotal evidence that waivers were sometimes granted on political grounds	Not available	Not available	Not available
Indonesia	Geographic targeting and individual targeting Identification of poor households varied by region Currently uniform poverty proxies are used.	Current coverage is 11%, of the poor, but rapidly increasing. In some provinces up to 89% of all poor families	Possibly as high as 39% May result from eligibility criteria unrelated to poverty (e.g , the capacity of families to meet their religious obligations)	Not available	May marginally improve access, 36% of beneficiaries report not using card	Not available
Thailand	Geographic targeting combined with means testing; income threshold combined with some group targeting (monks, veterans, children < 12yrs.)	80% of population living below national poverty line has a free health card	About 45% of card holders are non-poor relative to national poverty line	Not available	No systematic evidence. Anecdotal evidence that some card holders do not use their cards due to the low quality perceptions	Not available
Chile	Income thresholds and other poverty proxies + targeting by type of service (lower level care is free)	Above 90%	Above 50%	Not available	Indigent beneficiaries of FONASA receive free care in public hospitals and health centers Their per capita utilization rates are as high as those of non-indigent beneficiaries of FONASA Thus, system promotes equity in access and in financing	Indigent and low-income beneficiaries of FONASA incur relatively small out-of-pocket health spending in comparison with higher-income beneficiaries and non beneficiaries

Cambodia has been attempting to reallocate the government's budget for health care on the basis of regional poverty. Success, so far, has been limited, as shown in **Error! Not a valid bookmark self-reference.**. The figure shows the per capita government health budget allocated to each province in 1999, normalized between 0 and 1, and the equally normalized illiteracy rate (as a proxy for poverty) in the same year. To be equitable, the allocation of public health budgets should at least be correlated with illiteracy, or follow the same pattern as illiteracy. Both measures are indeed positively correlated, with a Pearson correlation coefficient of 0.39. This means that the government has allocated its recurrent health budget more or less according to illiteracy, generally sending more money per capita where illiteracy (and thus poverty) is high, and less where illiteracy is low. Yet the correlation is weak and there are grave exceptions. It can be seen from the figure that many provinces where illiteracy is relatively high – Kampong Speu and Siam Reap are examples– the per capita recurrent public budget is relatively low. Cambodia may be a special case because of the country's high reliance on donor assistance in the health sector, although user fees constitute the bulk of health financing, and in these high-illiteracy provinces the public budget is inequitably too low. Increasing the per capita allocation of public resources in the poorest provinces of Cambodia would enable the health facilities substantially to lower their user fees, or to remove them completely. Such a reallocation would be equitable on a national scale and it would greatly improve access to health services by the poor living in those provinces.

Figure 12 Cambodia: Per capita allocation of government health budget, 1999



In the poorest countries reviewed, particularly in Kenya and Ghana, coverage of the poor by waiver mechanisms was low. This is not surprising since in Kenya health care providers were not reimbursed for the value of services given to waived patients. In fact, in Kenya members of the health staff were reluctant to grant waivers. In Ghana there was financial compensation to providers for free care (see Table 30), but the flow of funds was uneven and late. In countries such as Cambodia and Indonesia coverage of the poor was low either because of a lack of funds (Indonesia) or because the system was new and there was limited awareness about it among the target population. Countries with high coverage, Thailand and Chile, were also the countries richest in the sample. Both those countries, however, had high levels of leakage. This is not surprising since both defined income levels for eligibility way above their official poverty line.

Virtually no information was available about the administrative cost of waiver systems. Cambodia's EF kept track of administrative costs or had had their costs evaluated. Such costs were high in projects which had a high component of (relatively very expensive) expatriate labor –Sotnikum and Phnom Penh Urban Health Project.

Likewise the is no systematic effort in place in any of the case countries to assess the impact that protection systems have had on rates of utilization of health services and on out-of-pocket expenditure by the poor. The ad-hoc evaluations conducted in Cambodia suggest that EF do promote greater utilization of services by the poor. In rural areas (Sotnikum) this requires that the protection mechanism not only waive poor patients from use fees in health facilities, but also that they reimburse these patients for their health-seeking related costs, such as travel and food. Evidence from Chile (Bitran 1995) also shows that the beneficiaries of waivers enjoy utilization rates for some services that are as high as those of higher-income, self-financed affiliates of the public insurer.

4.2 Financing of waivers and exemptions and design and implementation features

(a) Funding

With the exception of Chile and Cambodia's EFs, all other case study countries were characterized by a lack of public funding to pay for waivers and exemptions. Kenya simply did not contemplate the creation of a fund to pay for the incremental cost of waivers in public health facilities. Ghana, Zimbabwe, Indonesia, and Thailand had such a fund but the level of resources allocated to it was insufficient to finance waivers for the entire target group. Thailand's case is peculiar because although that country had not been able to cover all of the poor with its free health cards (it covered only 80 percent of them), it had a high level of leakage. Indeed, it is estimated that 45 percent of card holders were above the national poverty line. Thus, Thailand did not lack funds to finance its waiver policy, but rather was poorly using its available funding. Cutting some of the leakage to non-poor beneficiaries would free up enough revenue to finance free cards for the uncovered poor. Chile's situation was in a way similar to Thailand's: coverage of the poor was even higher, but according to recent estimates, leakage was substantial. A reduction in leakage, if at all possible, would enable Chile's government to provide more and better care for the poor, or to reduce general taxes.

(b) Health benefits covered

Most countries in this review failed to define explicitly the set of benefits subject to waivers and exemptions particularly as it pertains to curative services. Cambodia is making at attempt at defining two basic packages, the *minimum* and the *complementary* package of health services, the first for health centers and the second for hospitals. However, the prospect of granting waivers that would cover the entire set of services in these packages has not been contemplated to date. Chile's National Health Fund explicitly states that all primary and preventive health services provided in ambulatory health facilities are to be given at no charge to its beneficiaries. In the case of hospital-based services all care is supposedly to be given to the indigent, yet limited funding often results in rationing through waiting periods which can last several months.

(c) Existence and clarity of national policy of waivers and exemptions

With the exception of Cambodia, all other countries in the review had an explicit national waiver policy and all had an explicit policy for exemptions (all exempted certain categories of preventive services for all citizens). At the same time, most of the case study countries included in this paper have experienced problems related to their eligibility criteria. Lack of clear identification criteria seems to be one major problem. Often, telling the poor from the non-poor depends to a large extent on the subjective criteria of

the person in charge of determining eligibility. In Kenya, for example, staff in government health facilities used 10 different poverty proxies to establish eligibility for waivers. In Ghana health facilities seem to have several different definitions of the term "pauper", or the subjects of waivers. Likewise, in Chile there exist multiple criteria for determining eligibility and this has been a source of conflict between different government entities over some patients. In Chile, municipalities and hospitals often disagree on which of the patients are to be waived. Other countries experiencing similar programs have gradually improved clarity of eligibility criteria. Such is the case of Indonesia which has now established four criteria to identify the poor. In Thailand, the identification of the poor was initially up to the discretion of directors of public facilities but was later substituted by an income cutoff point. The lack of clear guidelines for granting waivers for user fees diminishes hampers the success of the waiver policy, and makes the monitoring of success a difficult task, and paves the way for a misallocation of subsidies through leakage.

Formulating clear identification criteria is a necessary but insufficient condition to make a system of waivers work. It is also crucial that identification criteria be applicable and easily verifiable. In Zimbabwe, for example, establishing eligibility proved cumbersome if not impossible since target beneficiaries were required to produce information sometimes not available to them. Thailand established an income cutoff point for eligibility, but since the target population belongs mostly to the informal sector, is highly mobile, and receives some in kind income, determining actual income is difficult and subject to arbitrariness. The foregoing discussion leads to a questioning of the appropriateness of using the income criterion alone for eligibility determination. Case information points to a need to complement to combine the income criterion with other information, or to drop it as use instead other, more observable poverty proxies. In this respect there is general such thing as a general prescription except that the definition of poverty ought to respond to local circumstances and be adapted to the specific cultural context.

(d) Taking into account the multiple dimensions of vulnerability of the poor

In most cases reviewed here, possibly with the exception of Chile, the poor often are deterred from claiming waivers as they feel ashamed of being poor. In Cambodia the staff of a large public clinic in Phnom Penh requires that waiver applicants be subject to a public means test in front of all other persons in the waiting room. Shame commonly leads to prospective applicants to forego their right to request a waiver. In Thailand, stigma also seems to be a problem limiting access by the poor, as the following statement illustrates:

> "Sometimes I self-treat because I do not want [the health worker] to complain that I often get free drugs from the health centre" [a poor from Thailand] (Gilson, 1998)

A similar situation was reported by a health official from Ghana:

> "On one occasion we had 11 patients who claimed they were paupers we informed that we would publish them as paupers by the following day. After all of them were photographed 4 of them came to settle their bill in full. This is an indication there are those who can afford to pay and yet will refuse to pay." (Garshong, 2001)

(e) Assigning responsibility for determination of eligibility

Eligibility may be determined by persons or entities within or outside of health facilities. Examples described in this paper show a variety of situations. In Kenya and Ghana eligibility is determined by health facility staff; in Zimbabwe by social welfare offices; in Thailand, Indonesia, and in certain provinces of Cambodia by the combined and coordinated work of health staff and other government officials (for example village leaders) and clerks; and in Chile by the separate and at times conflicting action of facility staff and municipal authorities. There is no single answer to who should be responsible for the exemption process but those engaged in eligibility determination should be aware of the selection

criteria, adequately trained to carry out their job, and informed about the financial and other constraints governing the protection awarding process.

(f) Updating fees and income eligibility thresholds

Most of the countries have had problems with adjusting fees and income thresholds to changing circumstances. In Ghana and Kenya, for example, the real value of user fees real has gradually eroded due to inflation, leading to spontaneous and unregulated attempts by providers to update fees in ways that may defeat the policy objectives. In Zimbabwe income cutoff points were not adjusted for inflation making it gradually more difficult for the poor to be eligible, and likewise in Thailand. When fees and income eligibility thresholds are not adjusted with circumstances, de facto protection policies may drift away from their original goal: those in the originally-defined target group are no longer captured by the income thresholds and facilities may set fee levels in way that may hurt the poor. It is therefore crucial that countries wishing to implement protection mechanisms design, from the very beginning, mechanisms for regular adjustment of fees and eligibility thresholds.

(g) Institutional aspects

Clear guidance to implementers and the availability of institutions, resources, and appropriately trained are essential for the effective application of pro-poor policies. No such clarity existed in most cases reviewed nor was there adequate staffing and supplies to carry out the tasks of waiving patients. In Ghana, for example, facility staff complained about increased workload and cost of stationery associated with the exemption and waiver procedures. In Kenya, the administration of waivers is cumbersome, on average lasting about 1-2 hours. The process of assessing and exempting patients is thereby often delayed or postponed. Countries wishing to implement protection mechanisms have to be aware that the granting waivers and exemptions is a complex process that requires institutional investments. Those designing the kinds of protection mechanisms for the poor discussed in this report should envision those needs for resources and should therefore contemplate mechanisms for creating and making them available on a sustainable basis. This means that there should be written guidelines for waivers and exemptions (with enough flexibility to allow for regional or local variation if necessary) and that health facilities or other agencies granting this protection should know and be reimbursed for their administrative costs.

Table 29 Waivers and exemptions in case study countries: Funding, design and implementation features

Feature→ / Country	Funding	Reach	General design and implementation					
	Public resources available to finance exemptions	Defined benefits package	Existence of national policy	Clarity of policy	Relationship between exemption criteria and national poverty criteria	Who decides?	Responsiveness of eligibility criteria to local circumstances	Adjustment of fees and income criteria to changing economic circumstances
Kenya	Not applicable, exemptions not compensated	No	Yes	No	No	Initially, local community leaders, then, health facility staff	Facilities replace income criteria by other poverty proxies	No· Implied lack of control on fee policy of each facility
Cambodia	Generous, donor-funded, sustainability with public funding currently not possible	No. But basic packages for primary health care and hospital care being implemented	No Only national user fee policy exists	Not available	No Eligibility established on an ad-hoc basis in each setting	In EFs decision made by EF staff, sometimes in coordination with health staff In other facilities health staff decide	Yes	Yes
Ghana	Funding covers only about 22% of resources required to cover exemptions	No	Yes	Unclear because of ambiguous definition of beneficiaries, or "paupers"	No	Health facility staff	Not available	No Implied lack of control on fee policy of each facility
Zimbabwe	Smaller allowances than actually required	No	Yes	Yes	Eligibility criteria increasingly outdated due to inflation	Social Welfare Office	Almost impossible to determine income threshold based on existing data	No· Income criteria not adjusted for inflation, increasingly below national poverty line
Indonesia	Insufficient No systematic data	No	Yes	Yes	No: Some of the eligibility criteria are non poverty related	Local community	Not available	Not available
Thailand	Insufficient	No	Yes	Yes	No Eligibility criteria way above poverty lines	Community	Almost impossible to determine income threshold based on available information	No
Chile	Yes	Initially not, but subsequently yes	Yes	Yes	No Eligibility criteria way above poverty lines	Municipality or facility	Not available	Yes

4.3 Design and implementation features influencing the supply of waivers and exemptions

(a) Provider compensation

Wilkinson noted that "there is a systemic conflict between a viable exemption scheme and a viable salary incentive scheme," in his report on the user fee system in Cambodia. By this he meant that it is unreasonable to expect that underpaid health staff that are responsible for, and have the ability to charge user fees, will act in accordance with general equity principles by providing appropriate levels of exemptions. Improving their income through fees will remain in obvious tension with the social aim of exempting the poor as long as budgets are inappropriate and accountability systems are absent. More generally when health facilities are viewed as a whole, there exists an equivalent tradeoff between the extent of exemptions and the aim to bridge any gaps in expenses or in revenue objectives through user fees.

The exemption component of Kenya's cost recovery policy is likely doomed to failure as long as the government does not restore to health facilities the revenue foregone from waivers and exemptions. Up until recently, Indonesia faced a similar situation, but currently health care providers do get from the government funds that supplement their budgets to defray waivers and exemptions. Zimbabwe, Ghana, Thailand, Chile and, more recently Indonesia, all have in common the existence of compensated funds for partial and full exemptions provided by government health facilities to patients.

The conclusion from the forgoing analysis is that a well-performing system of waivers and exemptions in government health facilities must be in harmony with institutional and individual staff objectives. More specifically, government funds or external funding from donors or lenders, are required to grant providers with the appropriate and minimum financial incentive to exempt the poor.

(b) Timeliness of compensation

A corollary of the preceding point is that compensated user-fee revenue should reach health facilities promptly. Only Thailand and Chile meet this requirement. In Ghana compensation to health facilities from SDF reportedly takes as long on 8 months to arrive. There, the need by facilities to meet expenses with concurrent funding is at odds with delayed reimbursement by the government. Where compensation exists, it must be timely; otherwise the cost of delayed reimbursement (for example the financial or opportunity cost) may be transferred by the provider to the poor, in the form of higher fees or lower (or fewer) exemptions.

Policies seeking to improve the protection of the poor should therefore seek to streamline any bureaucracy involved in the reimbursement of facilities for exemptions granted. Reimbursement procedures may be timelier in various ways. For example, the regular allocation of compensation funds from the central level to regional health authorities, or to regional funds, may make compensation more opportune and predictable. Or, in the absence of a decentralization framework, monthly budgets sent from the central level to facilities may include an "exemptions allowance" equal to the monthly target for that facility, with any (relatively smaller) adjustments for differences between actual and budgeted exemptions being made later.

(c) Harmonizing the incentives created by different payment mechanisms

Some case studies show that quality of services given to exempted patients is lower than quality for paying patients. Such is the case in Thailand. Even though providers are compensated there, "quality discrimination" may well be related to the incentives conferred by payment methods and levels which

differ across patient groups. Health facilities are paid mostly on a capitation basis, and the total capitation payment is below the revenue foregone by providers through waivers. At the same time, facilities get paid on a fee-for-service basis by paying patients or by the patients' insurer. Under this circumstance facilities have a strong motivation to select the "best paying patients", not only because reimbursement levels are higher but also because with a capitation-based payment system, facilities have an incentive to under-prov de services, especially in the absence of a tight monitoring system.

As the Thai situation illustrates, payment mechanisms and payment levels have an impact on the effectiveness of protection mechanisms. Countries adopting poor protection systems where providers are compensated for their provision of free or subsidized care to the poor must give serious consideration to the payment method and payment level. Adopting the wrong payment or the wrong level might result in some "crowding out of the poor".

Table 30 Waivers and exemptions in case study countries: Summary of Supply-side design and implementation features

Feature→ / Country	Supply-side design and implementation features					
	Existence and level of compensation	Compensation of administrative cost	User fee revenue kept at facility	Relationship between staff remuneration and user fee revenue	Financial significance of compensation for exempt patients, relative to full price	Time frame of compensation
Kenya	No	No: Granting of waivers is resource intensive but no compensation available	Yes	Staff reluctant to give waivers	Not available	Not available
Cambodia	Yes	Yes: But it does not include the cost of expatriate staff	99%	50% of revenue can be used to pay for salaries and accounts for up to 95% of staff income	Compensation equal to full fee	Monthly
Ghana	Yes· But cumbersome flow from central level to local level facilities	No Evidence that facilities and staff complain on this	Initially not, but subsequently yes	Revenue only to be used to pay for drugs and other non personnel expenditures	Not available	Evidence that reimbursement lasts on average 4 months
Zimbabwe	Yes: Albeit cumbersome flow from central level to local level facilities	No	Initially not, but subsequently yes	Not available	Not available	Reimbursement takes up to 8 months as it needs approval from Harare.
Indonesia	Initially not, but subsequently yes	No	Health centers can keep 25% of revenue; balance distributed with the budget allocation from the province	Not available	Not available	Delays in compensation
Thailand	Yes	No	Yes	Yes	Compensation is lower than fees received from paying patients (insured and uninsured)	Not available
Chile	Yes. Fees paid for exempted patients equal to fees paid for insured patients	Not explicit	Yes. But extraordinary budget allocations take into account user fee collected at facility	No	Fees paid for exempted patients equal to fees paid for patients insured in the public system. Provider indifferent between serving poor or non poor patient.	Not available

4.4 Design and implementation features influencing the demand for waivers and exemptions

(a) Disseminating pro-poor protection policies and mechanisms

Lack of knowledge on protection mechanisms by both health staff and potential beneficiaries is a recurrent issue in most countries with the exception of Chile, where the poor are screened by public facilities by an ad-hoc procedure if they have not been previously identified. Under-coverage will be a constant problem when the poor do not know they are eligible for free or subsidized care and when health facilities are not aware of whom to exempt

In Ghana, for example, most potential beneficiaries were unaware or misinformed about waivers and exemptions. Also, health facilities were not interested in disseminating information on waivers and exemptions. In Kenya, most inpatients and outpatients were unaware of waivers and exemptions. In Zimbabwe many of the poor had not applied for waivers because they did not know of the possibility of getting waivers through the SDF. In Indonesia, neither the poor nor health facilities knew that the health card officially entitled the holder to free primary care services and to free referrals. The problem of information dissemination seems to be especially challenging in Indonesia and Thailand. In Indonesia information on protection mechanisms originates at the provincial level and has to move down to districts, sub districts, villages, sub villages and finally to health facilities and to the target population. In Thailand, lack of information was considered a major obstacle to coverage of the poorest, leading to a series of major changes in the dissemination policy. Accordingly the village head was given a more proactive role in the application procedure. Also, in many countries (e.g., Indonesia) health staff was seldom trained to grant exemptions and waivers. The following statement from Gibbons (1995) illustrates this point:

> The staff at the health centers and health sub centers did not receive formal training to explain the uses and implementation. In Lombok Barat village, there was one meeting with the health center leaders and the district health official. The information given oat the meeting was minimal. After the meeting, the health center leaders were responsible for training the health sub center workers. This training of the health sub center workers consisted of brief conversations with the head of the corresponding health center. Little training actually occurred.

Countries wishing to implement mechanisms to mitigate the impact of user fees on the poor have to be aware that dissemination of policies is not done by circulating a few government leaflets. A dissemination policy is effective only when the poor and health staff know about protection mechanisms. For this to take place, some general recommendations can be made:

- Use different media (newspaper, radio, TV, house by house information, village meetings, schools to disseminate information on protection mechanisms
- Tailor dissemination mechanisms to special characteristics of the poor. For example, take into account that the poor tend to live further off, have less access to formal media, tend to be less educated, and have longer working hours.
- Introduce accountability in dissemination policy. For example make village heads accountable for disseminating information and evaluate performance of officials on this issue.

Table 31 Waivers and exemptions in case study countries: Summary of Demand-side design and implementation features and of monitoring and evaluation efforts

Feature→ / Country	Demand-side design and implementation features					
	Dissemination of information	**Access costs to exemption system**	**Social importance of stigma**	**Discrimination of the exempted**	**Accessibility to subsidized services without formal exemption**	**Existence of alternative providers**
Kenya	Majority of potential beneficiaries not aware of exemptions	Not available	Not available	Not available	No	
Cambodia	It varies Sotnikum's EF currently promoting scheme, but cautiously, to keep EF sustainable	No high	Important according to anecdotal information	No	No	Not good
Ghana	Majority of potential beneficiaries not aware of exemptions, health staff not knowledgeable of exemption categories	Not available	Not available	Not available		
Zimbabwe	About 50% of the population have never heard of the waiver policy	Evidence that participation costs are high and may deter demand	Anecdotal evidence	Not available		
Indonesia	Evidence that potential beneficiaries are often unaware of exemptions and that health staff does not know policy well	Yes: Anecdotal evidence that participation cost may deter demand	Not available	Not available		
Thailand	Problems revealed that the poor have difficulties accessing information on health card	Not available	Yes· Anecdotal evidence	Yes: Anecdotal evidence		
Chile	Not available	No	Not available	No		

- Make sure no major incentives exist to conceal information on protection mechanisms. As has been shown earlier, negative impact of protection mechanisms on staff's and facilities income may constitute a major obstacle to even the most sophisticated dissemination policy. This point clearly illustrates the strong relationship that exists among many of the major implementation issues related with the implementation of protection mechanisms for the poor.

- When the process is implemented in a top down manner (from national level to local level) opportunity should be given for discussion and clarification between official at different levels on how to implement the process and should not be limited to physically passing on government circulars.

4.5 Conclusion

Different countries have tried different approaches regarding waivers and exemptions for health services. Those that have carefully designed and implemented waiver systems (e.g., Thailand and Indonesia) have had much greater success in terms of benefits incidence than countries that have improvised such systems (Ghana, Kenya, Zimbabwe). Key to the success of a waiver system is its financing. Systems that compensate providers for the revenue forgone from granting exemptions (Thailand, Indonesia, and Cambodia) have been more successful than those who expect the provider to absorb the cost of exemptions (Kenya). Where waiver systems exist, performance will improve with the timeliness of the reimbursement. Other success factors include the widespread dissemination of information among potential beneficiaries about waiver availability and procedures; the awarding of financial support to poor patients for non-fee costs of care, such as food and transportation (as in Cambodia); and the existence of clear criteria for the granting of waivers, thereby reducing confusion and ambiguity among those responsible for managing the system and among potential recipients. Those facing the task of adopting a system of waivers face multiple design options. These include the following, among others: should exemptions be granted to whole groups or on the basis of individual targeting (the review finds that most systems are based on the latter)? Should waivers or exemptions be permanent or temporary? How frequently should eligibility be reassessed? Should waiver eligibility be determined ex-ante, in the household, or when individuals seek care in the facility? The review examines various approaches taken by countries, but assessing their relative practical merits is difficult, as the evidence is scattered and mixed.

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Appendix A: What are the Various Types of Targeting Mechanisms?

The various types of targeting mechanisms and their associated incentive effects (Table 1: Program Specific Targeting Mechanisms and Economic Costs) and costs (Table 2: A Comparison of Targeting Mechanisms) are summarized in the following tables:[48]

Table A1: Program Specific Targeting Mechanisms and Economic Costs

Program	Targeting Mechanism	Level of Associated Economic Cost	Source of Economic Cost	Level of Leakage
Cash Social Assistance	• Means-tests based on income or some proxy of income (variable highly correlated to income)	• High	• Depending on level of transfer alters labor supply, savings	• Moderate - high
Family Allowance	• Same as with cash social assistance, but can also be tied to family size and composition	• Moderate	• Same as with cash social assistance - also can influence fertility.	• Moderate - high
Food Transfers	• Subsidization of commodities consumed mainly by poor - improved targeting can be achieved through the packaging/marketing of commodity so that it is attractive only to the poor - "inferior good" method • Means-test for food stamps • Link distribution to social services primarily used by the poor.	• Low Moderate - high Low	• Labor supply, consumption decisions distorted prices.	• Low - moderate Moderate - high Low
Energy Subsidies	• Means-test • Subsidize energy source consumed by poor. • Exploit consumption pattern of poor through "lifeline rates "	• Moderate - high	• Over-consumption distorted prices	• High
Housing Subsidies	• Means-tests based on income or some proxy of income (i e , variable that is highly correlated to income).	• High	• Distorted prices alter savings and investment behavior.	• High
Public Works	• Wage level. • Form of wage • Location of work • Periodicity of wage payment (i.e., piece rate, hourly/daily, lump sum). • Type of work. • Duration of employment.	• Low - moderate	• Displacement of existing jobs labor supply	• Low - moderate
Credit Programs	• Communities, NGOs, and other local groups identify beneficiaries. • Small loans with short and frequent payback period. • Means-test	• Moderate- high	• Alter savings, investment, labor supply.	• Low - moderate

[48]. The following two tables were prepared by the World Bank. For the complete reference, see the web address at the end of Table A2.

	• Tied to receipt of unemployment insurance and/or social assistance • Additional self-screening through pre-advisory sessions and self-assessments.			

Table A2: A Comparison of Targeting Mechanisms

Mechanism	Advantages	Disadvantages	Administrative Requirements	Appropriate Circumstances
(0) Universal Provision	• Simple	• High leakage	• Minimal	• When the target group is broad-based
(1) Individual Assessment	•	•	•	•
(a) Simple Means Test	•	•	•	•
Records reported family income, size, and composition No attempt to value in-kind income, seasonal income, consider individual adjustments in needs or means No verification of income, except optional home visit to check housing quality	• Simplicity	• Inaccuracy • Respondents have strong incentive to lie about the information	• Staff to conduct interviews (may be done in field or office) • Record keeping	• Elements of self-targeting and/or geographic targeting to help improve accuracy • Low benefit levels, so absolute administrative costs must also be low
(b) Sophisticated Means Test	•	•	•	•
Adjusts family income according to family size, seasonality, costs of major items such as housing, university tuition, major medical expenses Requires verification of information through third parties or by having candidates submit paystubs, tax records, receipts	• Accuracy	• Higher administrative costs • Verification may work only for literate applicants working in the formal sector	• Staff to conduct longer interviews • Staff time for verifying information • Detailed record keeping	• High benefit levels (student loans, housing subsidies, large cash benefits) • Applicant pool literate and in the formal sector
(c) Proxy Means Test				
Objectively calculates synthetic needs score based on a series of variables that may include housing characteristics and location, family structure, occupation, education, gender of head, ownership of durable goods Calculation of index may be done by interviewers or computer	• Uniform systematic algorithm to weight variables • Not clear to applicant how to lie effectively • Gets at permanent income without having to adjust for seasonal or in-kind income • High marginal tax rate problem avoided	• Requires longer interview than simple means test • Weighing algorithm is inflexible, may not detect special circumstances such as catastrophic illness, natural disasters • Applicants may perceive system as arbitrary	• Staff to conduct interviews (may be done in field or office) • Detailed record keeping • Computerized option requires data entry capacity, sometimes at local level • Software design can be centralized • Previous analytical work and periodic updates to establish	• Broadly applicable • Especially useful when • (a) large benefit levels are to go to candidate pool from illiterate, informal sector, and • (b) access to basic infrastructure is so extensive that it does not distinguish need very well in less detailed assessments

			variables and weights	
(d) Social Worker Evaluation	•	•	•	•
Subjectively evaluates the same kind of information as used in proxy means test	• Can detect special circumstances	• Uniformity and consistency hard to ensure • Mixed record in practice • Applicants may perceive system as allowing favoritism, influence peddling	• Staff conduct interviews • Record keeping	• Broadly applicable
(e) Nutritional Status				
Weight for age Growth faltering Nutritional risk as figured by mother's fertility history, siblings' health history, family Socio-economic characteristics	• Objective, verifiable, accurate indication of need • More preventive focus, detects problems earlier • Preventive focus	• Curative orientation, waits until child is malnourished before intervening • Standards can be controversial • Results very sensitive to inaccuracy in weighing and recording and to child's state of hydration • Adds new information requirement in health services	• Growth monitoring capacity • High accuracy in growth monitoring capacity • Prior studies to determine risk factors and their weights • Training for medical staff in unfamiliar process	• Malnutrition widespread • Forms part of well-established preventive health package • Forms part of well-established health package
(2) Categorical (Group Targeting)				
By region (i e., oblast) Individual characteristics (i e., students, pregnant women)	• Simple	• Inaccurate unless linked to other criteria can lead to high leakage, does not detect special circumstances	•	• Poverty highly regionally concentrated or closely associated with specific individual characteristics
(3) Self-Targeting and (4) Targeting by Type of Service	•	•	•	•
Public works - form of wage, type of work Credit programs - (i e , size of credit training requirements) In-kind - subsidize goods or form of good/pattern of consumption peculiar to the poor	• Simple • Low cost • Low leakage	• Can have high administrative cost	• Marketing analysis to determine consumption patterns of the poor	• When there is clear demarcation of consumption patterns between the poor and non-poor

Source: Adapted from Administering Targeted Social Programs in Latin America and Uzbekistan Adjusting Social Protection, World Bank, 1994.

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~~9815~~	This paper has been revised, see Discussion Paper No. 9923
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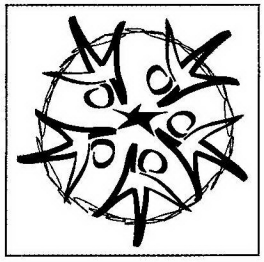

Summary Findings

In response to shortages in public budgets for government health services, many developing countries around the world have adopted formal or informal systems of user fees for health care. In most countries user fee proceeds seldom represent more than 15 percent of total costs in hospitals and health centers, but they tend to account for a significant share of the resources required to pay for non-personnel costs. The problem with user fees is that the lack of provisions to confer partial or full waivers to the poor often results in inequity in access to medical care. The dilemma, then, is how to make a much needed system of user fees compatible with the goal of preserving equitable access to services. Different countries have tried different approaches. Those which have carefully designed and implemented waiver systems (e.g., Thailand and Indonesia) have had much greater success in terms of benefits incidence than countries that have improvised such systems (Ghana, Kenya, Zimbabwe). Key to the success of a waiver system is its financing. Systems that compensate providers for the revenue forgone from granting exemptions (Thailand, Indonesia, and Cambodia) have been more successful than those who expect the provider to absorb the cost of exemptions (Kenya). Where waiver systems exist, performance will improve with the timeliness of the reimbursement. Other success factors include the widespread dissemination of information among potential beneficiaries about waiver availability and procedures; the awarding of financial support to poor patients for non-fee costs of care, such as food and transportation (as in Cambodia); and the existence of clear criteria for the granting of waivers, thereby reducing confusion and ambiguity among those responsible for managing the system and among potential recipients. Those facing the task of adopting a system of waivers face multiple design options. These include the following, among others: should exemptions be granted to whole groups or on the basis of individual targeting (the review finds that most systems are based on the latter)? Should waivers or exemptions be permanent or temporary? How frequently should eligibility be reassessed? Should waiver eligibility be determined ex-ante, in the household, or when individuals seek care in the facility? The review examines various approaches taken by countries, but assessing their relative practical merits is difficult, as the evidence is scattered and mixed

About this series...

The World Bank Social Safety Nets Primer is intended to provide a practical resource for those engaged in the design and implementation of safety net programs around the world. Readers will find information on good practices for a variety of types of interventions, country contexts, themes and target groups, as well as current thinking of specialists and practitioners on the role of social safety nets in the broader development agenda. Primer papers are designed to reflect a high standard of quality as well as a degree of consensus among the World Bank safety nets team and general practitioners on good practice and policy. Primer topics are initially reviewed by a steering committee composed of both World Bank and outside specialists, and draft papers are subject to peer review for quality control. Yet the format of the series is flexible enough to reflect important developments in the field in a timely fashion.

The primer series contributes to the teaching materials covered in the annual Social Safety Nets course offered in Washington, DC, as well as various other Bank-sponsored courses. The Social Safety Nets Primer and the annual course are jointly supported by the Social Protection unit of the Human Development Network and by the World Bank Institute. The World Bank Institute also offers customized regional courses through Distance Learning on a regular basis.

For more information on the primer paper series and papers on other safety nets topics, please contact the Social Protection Advisory Service; telephone (202) 458-5267; fax (202) 614-0471; email: socialprotection@worldbank.org. Copies of related safety nets papers, including the Social Safety Nets Primer series, are available in electronic form at www.worldbank.org/safetynets. The website also contains translated versions of the papers as they become available An ambitious translation plan is underway (especially for Spanish and French, some in Russian). For more information about WBI courses on social safety nets, please visit the website www.worldbank.org/wbi/socialsafetynets.